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Stepping carefully on sacred ground: The role of religion and spirituality in Norwegian psychotherapy

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Summary

Introduction

Religion and spirituality are essential parts of the human condition and, for many, they have a central role in both health and suffering. In psychotherapy, however, there is uncertainty about whether and how the spiritual domain should be addressed professionally. Increasing diversity and secularisation in Western societies such as Norway add to the dilemma. This study explores the role of religion and spirituality in Norwegian psychotherapy, in both the clinical and university contexts. The aim is to provide a more differentiated overview of the status quo and possibly make some recommendations for the future training of psychotherapists in Norway.

Methods

In a mixed-methods design, the study used statistical data collected from 260 mental health care professionals (one-third of this number are psychologists) in three Norwegian clinics, 650 psychology students from all four Norwegian universities that offer clinical training, and qualitative data was gathered from interviews with eight Norwegian psychologists who attempt to integrate the spiritual domain in their therapeutic work in different settings and specialities. One of the studies replicates a survey from 2005 and uses national norm data and current data for comparisons. Statistical and thematic analyses were used to extract results, and a literature review positions them in general international research.

Results

In contrast to the keen interest among students and the verified clinical relevance of spiritual and religious struggles as well as coping strategies related to spirituality and religiosity, this study's data show low inclusion of relevant topics in university training and an ambivalent clinical picture; while many mental health care professionals seem to be open to the topic, only few psychologists address it actively in therapy. However, those who do, experience an enhanced therapy process with gains for both their patients and themselves. Therapist self-disclosure is identified as a barrier, but adequate training seems to be lacking.

Discussion

Discussing the results in the context of an increasingly secular and diverse society, several connections became evident. While the need for culturally sensitive psychotherapy is growing

in Norway, traditional religious terminology appears to be an inhibiting factor, as it seems inappropriate in a secular health system. Existential terminology, however, could be more accessible to patients and professionals, as it addresses experiences of limitation and freedom, belonging and loneliness, guilt and responsibility, and body and mind as elements of psychological struggles. It therefore includes and exceeds pure religious or spiritual terminology. Appropriate training for psychologists should include not only knowledge, attitudes, and skills in the existential domain, but also self-reflection as a prerequisite for professional self-disclosure that does not violate ethical borders but crosses boundaries in the process of healing.

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Introduction

The spiritual dimension of life is an integral part of being human. In fact, in an integrated health care approach, it is of equal significance to the physical, psychological, and social aspects of health (Barbosa da Silva, 2013). Questions of meaning and purpose, the experience of guilt and forgiveness, emotions of togetherness with others or nature as a whole, religious faith or nonreligious connection with a higher dimension—all of these are inseparably tied to the human condition. The spiritual dimension does not only play a role in social life, such as in rituals and holidays, or in every day meaning making, but also in any crisis in human life, including physical and mental health challenges. Considered categorically, spiritual questions are essentially distinct from other qualities such as physical health, psychological stability, and social integration (Wilt et al., 2017). Therefore, the spiritual dimension is essential for the holistic understanding of human suffering. This perspective on patients was established as part of the palliative care movement when it started in the United Kingdom during the 1960s (Saunders, 1996). Psychological research and therapist training, however, which were primarily driven by behaviourist pragmatism and psychodynamic scepticism, avoided spiritual themes. However, during the past three decades, psychological interest in religion and spirituality has progressively increased (Pargament, Mahoney, Shafranske, et al., 2013). This trend has been slightly slower in Europe, but it has become noticeable. Recent studies conducted in Norway and Germany (Holmberg et al., 2017; Utsch et al., 2014) demonstrate the importance of integrating the spiritual dimension into therapy and counselling for patients, and the necessity for more study is regularly emphasised.

The main focus of mental health research with a focus on spiritual or religious questions has been on patients. The caregivers' religiosity and spirituality and its impact on therapy and counselling processes has rarely been studied, and, in those rare cases, primarily from a descriptive standpoint (Hofmann & Walach, 2011; Holmberg, 2012). For a long time before, the caregivers' attitude and special competence in in spiritual and religious issues did not seem to be of wide interest. This may be related to the conventional idea that psychotherapy and counselling can and should be conducted in a professionally neutral or generally tolerant manner, which means that private orientations, such as religiosity, should (and could) be disregarded. It may also stem from a desire to emphasize the scientific and professional character of clinical psychotherapy and psychological counselling and to distinguish it from any spiritual or religious "treatment" of psychiatric or psychological disorders (Boessmann,

2017), thus preserving professional quality. This critical attitude is in contrast to the existence of numerous spiritual interventions that are in fact applied in private and clinical praxis, mostly by professionals with a certain personal conviction (Utsch & al., 2017), without appropriate empirical foundation. This contrast between theory and practice is a challenge, also in the professional discourse about spirituality in psychotherapy, which often seems misguided as a result of prejudice. Furthermore, the line between what can and cannot be regarded as spiritual does not seem clear at all. Increasing secularisation, as is the case in Norway with its diversification in perception and language, adds to this challenge (Furseth et al., 2019). Only recently have reciprocal dynamics in therapy become a greater focus of research, including the influence of therapists' attitudes and interests (Errington, 2017; Spero, 2010). In Norway, recent contributions to research on spiritual competence of health care professionals have explored professionals' attitudes towards the integration of the existential, spiritual, and religious domains into patient treatment (Frøkedal et al., 2019). However, spiritual topics are seldom incorporated into psychological training (Reme et al., 2009), and, when they are, the focus tends to be on the patients and their needs rather than on the professionals, by allowing self-reflection on their attitudes and influence related to this topic in the therapy room (Gross & Freund, 2017).

Background stories

Every story has a history, and every scientific study has a background. This background is partly scientific, which is related to theory, prior research, and professional praxis, and partly personal, which is related to the researcher's biography, motivation, and personal experience. To read and understand the results from this thesis in context, the reader needs information about both the scientific and the personal parts. Therefore, before expanding on the central concepts, clinical relevance, and social context of the study in the form of a literature review, I commence with three personal perspectives on this research.

Biographical motivations for this study

Before embarking on a PhD project on the professional integration of spirituality and psychotherapy, I had been a practitioner for more than 15 years. I worked as a psychotherapist for couples and individuals, a coordinator in ambulant hospice care, and a trainer for palliative care professionals. Because of my background as theologist and psychologist, I was often consulted regarding questions of religion and spirituality. Existential questions are common topics, especially in the palliative care context.

My professional training in psychology, however, barely equipped me with theories or methods to talk about religiosity therapeutically, and I found it challenging to balance the professional relationship, clients' expectations of spiritual guidance, and my own religious biography. There were many unanswered questions, such as, if I believe that central Christian concepts, including hope, forgiveness, and gratitude, have an important impact on mental health and conflict regulation, how can I use them in therapy without violating the ethical boundary of religious neutrality? How should I answer clients' question regarding my own spiritual position? When clients tell me about a mentally destructive faith, how can I offer alternative emotional and cognitive guidelines without revealing, at least partially, my own theological convictions or provide spiritual guidance?

Questions such as these are challenging. Nevertheless, I have experienced many a therapeutic success that was rooted in spiritual resources; clients found strength and comfort in their faith in times of psychological crisis, couples embarked on new beginnings in their relationship that were founded on religious ideas, and individuals linked positive changes in their self-understanding to changes in their image of God. In many cases, religiosity and spirituality, as I encountered them in therapy, were closely linked to psychological challenges as well as mental wellbeing. They were not, however, part of the standard anamnestic inquiry I had been taught in university psychology.

The investigation into an ethically and methodologically appropriate role for religion and spirituality in professional psychotherapy has, therefore, been strongly motivated by my own academic education and professional experience.

Jehovah's forgotten child

As an example of such an experience, I will outline a therapy session (in anonymised form) that contains various religious aspects of a and marks a turning point in the client's psychological progress.

As an adult, my client had left the church of the Jehovah's Witnesses, which she had experienced as increasingly controlling and hostile to healthy social relations outside the community. Many years later, she consulted me for depressive symptoms that seemed to be contradictory to an otherwise balanced social and professional life. When I asked her about significant losses in her life, she hesitated, and then she told me about the birth of a stillborn child while she still was a member of the Jehovah's Witnesses. The elders of her community came to visit her in hospital to offer greetings from the fellowship and inform her about the community's doctrine.

The child, they said, was obviously not meant to live; it had not been accepted by Jehovah to partake in the kingdom and would from now on be in eternal oblivion. She would never see the child again, so the elders' advice to my client was to forget about this child and focus on the future with Jehovah. At this point in our dialogue, there was a silence. My client was obviously extremely moved, and her body language signalled pain, grief, and, somehow, buried anger. As a therapist, I felt that I had to choose my next question carefully. Should I ask her to verbalise her feelings? Should I ask about the loss, the potential trauma of birthing a stillborn child? Should I comment on the male dominance in this scenario?

Intuitively, I asked "What is the child's name?" My client replied, I repeated the name, and there was silence again, this time of different quality. She then talked about her grief and her love and said that the child had always been alive in her heart. In our next session, she appeared relieved and more upright. She said that, in our previous session, the child's name had been said aloud for the first time, "like in a baptism". We talked about her faith, about life after death, memories, and the meaning of sadness. This was not a talk with definite conclusions, but rather an open space for her to freely enter a dimension of spirituality that, in her biography, had been blocked by rigid doctrine. I saw this episode as a turning point on my client's journey from depression towards a more deeply integrated life.

Stories such as this one motivated my research. Not all are as clearly religious as this one, but many have spiritual or religious elements that I consider important, either as a cause of suffering or as part of a solution. I am convinced that both therapists and clients can profit from more professional integration of religious aspects in psychotherapy and adequate training and supervision.

Stepping carefully on sacred ground

The title of this thesis and one of my articles was inspired by a story from the Old Testament (Exodus 3:1-8a, New International Version (The Bible, 2011)):

Now Moses was tending the flock of Jethro, his father-in-law, the priest of Midian, and he led the flock to the far side of the wilderness and came to Horeb, the mountain of God. There the angel of the Lord appeared to him in flames of fire from within a bush. Moses saw that, though the bush was on fire, it did not burn up. So Moses thought, "I will go over and see this strange sight—why the bush does not burn up."

When the Lord saw that he had gone over to look, God called to him from within the bush, "Moses! Moses!" And Moses said "Here I am". "Do not come any closer", God said. "Take off your sandals, for the place where you are standing is holy ground".

Then he said, "I am the God of your father, the God of Abraham, the God of Isaac, and the God of Jacob". At this, Moses hid his face, because he was afraid to look at God. The Lord said "I have indeed seen the misery of my people in Egypt. I have heard them crying out because of their slave drivers, and I am concerned about their suffering. So I have come down to rescue them from the hand of the Egyptians and to bring them up out of that land into a good and spacious land, a land flowing with milk and honey—the home of the Canaanites, Hittites, Amorites, Perizzites, Hivites and Jebusites. And now the cry of the Israelites has reached me, and I have seen the way the Egyptians are oppressing them.

So now, go. I am sending you to Pharaoh to bring my people the Israelites out of Egypt". But Moses said to God "Who am I that I should go to Pharaoh and bring the Israelites out of Egypt?" And God said "I will be with you. And this will be the sign to you that it is I who have sent you. When you have brought the people out of Egypt, you will worship God on this mountain".

Moses said to God, "Suppose I go to the Israelites and say to them, 'The God of your fathers has sent me to you,' and they ask me 'What is his name?' Then what shall I tell them?" God said to Moses "I am who I am. This is what you are to say to the Israelites: 'I am has sent me to you'". God also said to Moses "Say to the Israelites, 'The Lord, the God of your fathers, the God of Abraham, the God of Isaac, and the God of Jacob, has sent me to you'. This is my name forever, the name you shall call me from generation to generation".

This ancient narrative embraces several aspects that I find mirrored in my clients' histories as well as in my own spirituality and my experience of psychotherapy. They are part of the motivational foundation of this thesis.

- *"I will go over and see this strange sight—why the bush does not burn up"*. Moments of spirituality, in my clients' and in my own life, can be moments of curiosity and discovery, when daily life is interrupted and the profane is in touch with the sacred.
- *"Take off your sandals, for the place where you are standing is holy ground"*. An encounter with the sacred provokes respect. "Stepping carefully on sacred ground" expresses an attitude that I find in my clients and in myself in moments of spirituality, in my approach to my clients' experiences, and even in my approach to the topic of my

research. When I asked participants in my studies about spirituality, I encountered similar ethical boundaries as in encounters with clients, and these boundaries require awareness and mindful handling.

- *"I have indeed seen the misery of my people (…). So I have come down to rescue them (…) and to bring them up out of that land into a good and spacious land, a land flowing with milk and honey"*. Empathy and the prospect of change are at the core of this narrative. They are also core elements of good therapeutic relationships. This similarity between the dynamics in spirituality and in psychotherapy, as I experience it, is a good reason to consider spirituality as a therapeutic resource as well as to be aware of differences and the required demarcation lines.
- *"Moses said to God 'Who am I (…)?'—God said to Moses, 'I am who I am*'". In my experience, religion, spirituality, and the existential question of identity are closely linked, as are the self-image and a possible image of God. This biblical narrative embraces both the connection of identity and religiosity and, in the enigmatic name of God, "I am who I am", the dimension of change and development. Discovering oneself, becoming oneself, and discovering the name of God can be the same thing, spiritually speaking. This closeness of spiritual and psychological dynamics, as I experience it, motivates me to research connections and differences.

The motivation of the researcher, whether educational, professional, or spiritual, affects the research process, from the formulation of the research question to the interpretation and presentation of the results. The researcher's spiritual experience can be an additional source of information as well as a risk for bias. Nevertheless, it is valuable information for the reader and is, therefore, in an appropriate place in the introduction of this thesis before moving on to the more objective grounds of the central concepts, clinical relevance, and historical and social context of the study.

Central concepts

From the outset, the discipline of psychology has had a dualistic structure that attempted to explain human experiences and behaviour, referring to natural sciences such as biophysics on the one hand and social sciences and philosophy on the other (Wulff, 1996, p. 21). From W. Wundt's experiments on perception to B.F. Skinner's learning theory and modern neuropsychology, influential researchers have promoted a materialistic, positivistic approach. Simultaneously, works such as C.G. Jung's publications on symbols, W. James' use of qualitative research in psychology, or I. Yalom's descriptions of existential psychology

represent a different aspect of the discipline that refers to subjectivity, phenomenology, or critical philosophy as ways of understanding the human mind. While positivistic psychologists have regarded religion and spirituality to be unscientific and, thus, un-psychological phenomena, others have seen it as an integral element of human life that requires psychological attention to understand its potential, both harmful and beneficial. This thesis is clearly positioned in the latter psychological tradition.

The discipline of "psychology of religion", as it was initially termed (Starbuck, 1899), experienced a shift in names and research topics parallel to the cultural changes it was subject to. Globalisation and the awareness of religious diversity led to an emphasis on "religiousness", which acknowledges the variety of different religious traditions globally and their individual realisations (Smith & Hick, 1991, p. 194), and to the name "psychology of religion and spirituality", which acknowledges the large group of individuals who describe themselves as believing in some higher power without belonging to any faith community (Watts, 2017). Secularization and the growing number of non-believers in societies with religious heritages has led to extensive research on meaning making, which can be regarded as the underlying psychological processes for both religious and non-religious world views.

Defining the existential, the sacred, religiousness, spirituality, and meaning making

There is an ongoing discussion regarding the appropriate definition of terms related to this field of research, such as "religiousness", spirituality", "faith", and "the sacred". A widely used theory by K. Pargament places "the sacred" at the core of a psychological understanding of religious and spiritual behaviour. He places a "sacred ring" around a "sacred core" that contains the divine, God, or another transcendent reality, which includes a variety of elements such as "nature", "marriage", or "meaning" that can be analysed psychologically and addressed professionally in psychotherapy (Pargament, 2011, pp. 36-42). Koenig (2008) notes that research will be difficult as long as the concept of spirituality remains "fuzzy" and asks for more academic unity. Harris et al. (2018) conducted a meta-analysis of definitions that have been used during the last 30 years of research and conclude with the proposition

> *"that **spirituality** is a search for or relationship with the sacred; **religiousness** is ritual, institutional, or codified spirituality which is culturally sanctioned; **faith** is a synonym for spirituality and/or religiousness; and **the sacred** is manifestations of the divine, existential meaningfulness, or an ultimate concern as perceived by an individual".*
>
> (Emphasis added by me)

In a recent essay, Paloutzian and Park (2021) criticise these composite definitions as manifestations of a basic problem; by including "the divine" and "the sacred" in the definitions, psychologists link the discussion to elements "outside neutral science". Paloutzian and Park suggest that psychologists should not only consistently use the term "religiousness" instead of "religion", which is not a psychological concept, but also "focus on meaning systems and meaning making processes, some of which include religiousness and spirituality". Slife and Reber (2021) accuse their colleagues of being "neonaturalistic" and state that there is no such thing as neutral science and that theistic paradigms may be useful to scientists who want to remain in proximity to data collected from believing study participants.

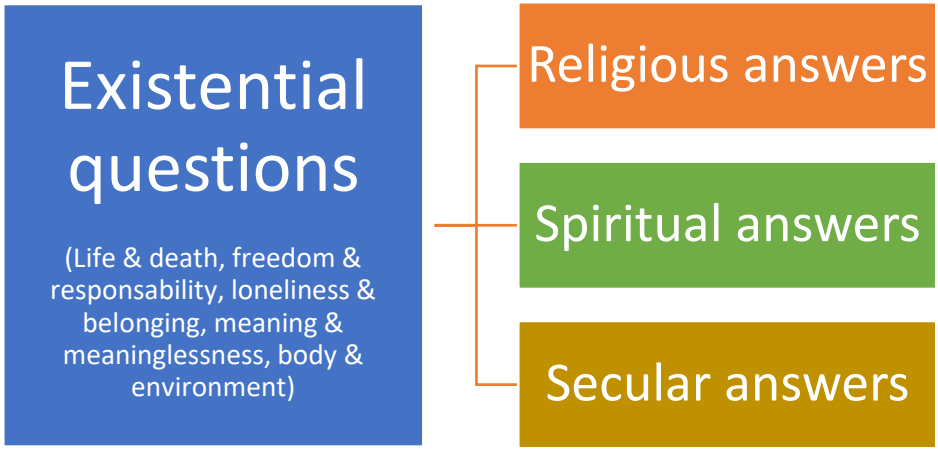
To conclude, defining the core of religion and spirituality from a psychological perspective is a challenging task, not only because of the shifting cultural significance, but also because of the intangible nature of the object that religion and spirituality are aimed at. None of God, the transcendent, or the divine can be examined or even described in scientifically satisfactory terms. R. Otto's description of the sacred as "mysterium tremendum et fascinans" and "numinosum" (Otto, 1929) mirrors both the existential importance and the inaccessibility. Psychology cannot make valid statements on the existence of God or any other concept that faith communities may consider as the basis of their experience of the sacred. It can, however, make statements about human behaviour and experience, spirituality, and religiousness among people.

For research purposes, it is therefore necessary to find an epistemological point of departure that can lead to valid claims and can be linked to psychological theories. While remaining within the realm of observable human experience, "the existential" can offer such a point. Based on existential philosophy, psychologists have proposed several core challenges that every human has to face. A classical categorisation (Yalom, 1980) suggests four main existential questions that concern death, freedom, loneliness, and meaninglessness. Later publications have criticised this approach as too destructive and emphasised the positive aspects in the existential challenges, such as meaning, relatedness, and faith (Wong, 2020), and have proposed further categories such as the bodily dimension of being in the natural world (Binder, 2020). Whatever the framework of the existential questions, the answers can be quite different, depending on the culture, personal experience, and relational context (Austad et al., 2020). In addition to secular answers that draw on natural science or modern Western ideas, such as the present-day pursuit of individual happiness and other targets of meaning making, religion and spirituality have long traditions that provide answers through concepts such as life after death,

ethical rules based on holy scriptures, the opportunity to belong to faith communities, or finding meaning in a spiritual life. Figure 1 illustrates this connection between existential questions and religious, spiritual, or secular answers, which is one of the basic assumptions of this thesis.

Figure 1

Existential questions and religious, spiritual, and secular answers



When referring to literature in this thesis, I use the relevant terminology according to the way the respective authors use it in their publications. In my own argumentation, however, I attempt to use concise language to maintain the connection between the existential domain on the one hand and individual religiousness as described in the field of psychology of religion and spirituality on the other hand.

Psychotherapy

The American Psychological Association (2012) refers to J. Norcross for a working definition of psychotherapy as

> *the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviours, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable.*

However, psychologists are far from unanimous on what constitute “clinical methods” and “established psychological principles”. From the start of the “talking cure”, developed by J. Breuer and S. Freud during the 1890s, psychotherapy has followed different principles and used a variety of methods, some of which were based on scientific evidence and others on more general theories regarding human nature (Depreeuw et al., 2017).

In Western cultures, this diversity persists, but three psychological schools dominate both research and practice: cognitive behavioural therapy, psychodynamic approaches, and systemic therapy, and each one has many sub-divisions. The role of religion and spirituality differs significantly in the different directions and sub-divisions.

Cognitive behavioural therapy (CBT)

Based on the learning principles of behaviourism and experimental ethics, classical behavioural psychology addressed religion and spirituality as individual and social attempts to control behaviour (Wulff, 1996, pp. 119-146). Prominent figures of this first wave of behaviour therapy, such as G. Vetter and B.F. Skinner, acknowledge the evolutionary advantage of religiosity but largely reject traditional religion as “explanatory fictions” (Skinner, 1971, p. 196). The second wave of behaviour therapy, influenced by the cognitive turn in psychology, focussed on the interaction of behaviour, feelings, and their cognitive framework. One of the pioneers of the cognitive therapies, Albert Ellis, positioned himself firmly against religion, which, in his view, “doesn’t help at all; and in most respects it seriously sabotages mental health” (Ellis, 1984, p. 5). The third wave, however, started during the 1990s and focussed on aspects such as mindfulness, acceptance, and values as important factors for mental health. Modern psychotherapy concepts, such as "acceptance and commitment therapy" or "dialectical behaviour therapy" call for holistic openness. This has helped to make CBT more compatible with religious and spiritual issues (Heidenreich & Michalak, 2013). Experts, also in Norway, discuss the advantages and risks of using meditation techniques without integrating the spiritual framework they stem from (Binder & Hjeltnes, 2021).

Psychodynamic therapy

In the psychoanalytic tradition, the relationship between religion and psychology has been conflicted from the outset. The personal conflict between S. Freud and C.G. Jung is almost symbolic; Freud criticised religion profoundly as an illusion both patients and society needed to be liberated from (Freud, 1927), whereas Jung’s theory of archetypical symbolism appreciated both religion and spirituality as valuable sources for therapeutic work (Corbett,

2013). After a euphoric beginning, their relationship ended in open discord—a discord that was apparent in the psychological discourse during the following decades (Falzeder, 2020). Later psychodynamic theories followed Freud in the critique of institutionalised traditional religion but argued for spiritual approaches that value humanistic ideals. For example, E. Fromm described the premises for a "humanistic religion" (Fromm, 1980). In his later publications, A. Maslow was interested in "peak experiences" and other forms of spiritual and mystical phenomena as subjects of psychological investigation (Maslow, 1961; Maslow, 1970).

Modern psychodynamic approaches provide various means to explore and understand the function of spirituality religious belief that can be salient to mental health (Shafranske, 2009). Attachment theory and therapeutic models that examine God images as representations of early relations have made valuable contributions to both psychological theory and clinical practice (Reineke & Goodman, 2017; Staalsett et al., 2010).

Systemic therapy

Originating from diverse sources during the 1980s, systemic therapy had a differentiated relation to religion from the outset, often regarding religious systems as explanatory contexts for social behaviour and experience (Levold, 2012). On the one hand, its epistemological connection to constructivism made it easier to integrate religious and spiritual concepts into treatment as clients' individual constructions, while, on the other hand, the systemic rejection of singular truths and religions' claims of truth could make interaction challenging (Ludewig, 2011). Today, systemic therapists discuss the "uncomfortably important place of spirituality" in therapy (Errington, 2017) and provide techniques to address spirituality without manipulating clients (Ybañez-Llorente & Smelser, 2014).

Overarching research

Over the last decades, research on religion and spirituality in psychotherapy has increased considerably, independent of psychological traditions. The spiritual dimension has been demonstrated to be of vital relevance to clients, both as a cause of suffering and spiritual struggles (Exline & Rose, 2005), and as a resource for growth and coping (Pargament, 2011). In recent years, research on the effect of spirituality on mental health has expanded significantly, with meta-analyses showing positive effects (de Bernardin Gonçalves & Vallada, 2019; de Rezende-Pinto et al., 2019; Gonçalves et al., 2015), areas of risk (Ashouri et al., 2020), and the effects that poor health can have on spirituality (Hvidt et al., 2017). More specifically, spirituality is being discussed as factor in therapeutic dialogue. Spiritual bypass, for instance,

is the tendency of certain individuals to escape personal issues and conflicts by employing a spiritual vocabulary and hiding behind spiritual worldviews. This can be a barrier to psychological transformation and must be adequately addressed during treatment (Clarke, Giordano, Cashwell, & Lewis, 2013; Navaneethan, 2016; Picciotto, Fox, & Neto, 2018).

Norwegian psychotherapy

Clinical psychology claims to be based on solid scientific theory and evidence of success (Campbell et al., 2013). In Norway, the professional title "psykolog" is protected by law and can only be used by professionals with an appropriate, usually, six years of university training. Both theory and practice of psychotherapy should follow an inclusive approach that considers the usefulness of different traditions of psychotherapy (Norsk Psykologforening, 2021). "Norwegian psychotherapy", as mentioned in the title of this thesis, therefore means psychotherapy offered by licensed professionals with different theoretical backgrounds that relate to university teaching of clinical psychology.

Summary

The relationship between psychotherapy and religion is varied and has developed significantly during the last century, both in the different traditions of psychotherapy and in an overarching perspective. It is therefore appropriate for this study to not differentiate between traditions as though this could make a difference in today's psychological landscape, but to regard psychotherapy as a single approach with many variations across psychological schools and many similarities in clinical practice (Tschuschke et al., 2015). However, not everybody who call themselves psychotherapists uphold the same standards of quality in training and practice. On the contrary, especially movements that teach and practice forms of spiritual healing have been accused of a lack of professionality (Petzold et al., 2009). In Norway, as in other European countries, psychotherapy is obliged by health law to follow quality standards.

Clinical relevance

Not only is the theoretical relevance of religion and spirituality in psychology controversial, the same holds true for their clinical relevance. While some clinicians consider religion and spirituality as strictly private matters that should only be addressed under exceptional circumstances and on the patients' explicit request (Petzold et al., 2009), others see spiritual aspects as indispensable factors in a holistic view of human nature and, therefore, essential in any psychotherapy (Marquis & Wilber, 2008).

There seems to be agreement on the special needs of highly religious patients (Worthington & Aten, 2009) or people who have psychological problems with clear religious/spiritual elements, such as mental distress after sexual abuse by priests (Rossetti, 1995) or cult experiences and other forms of spiritual abuse (Ward, 2011). However, it is not a common clinical stance that there is a general necessity to integrate spirituality into psychotherapy (Captari et al., 2021); this appears to be a claim brought forward more often by psychologists with special interests and in fields with a high affinity to pastoral care, such as palliative care, psycho-oncology, or treatment of complicated grief.

The APA handbook of psychology, religion, and spirituality (Pargament, Exline, et al., 2013; Pargament, Mahoney, & Shafranske, 2013) does not only present the content, form, and psychological relevance of religion in different cultures and sub-cultures and discuss concepts, theory, and assessments, but it also analyses the correlation of religion and spirituality for numerous clinical settings and diagnoses, such as substance abuse, chronic illness, eating disorders, or trauma therapy. In the following, I present some of the most important fields of research. They are relevant to this study because they represent general concepts that apply to different areas of psychotherapy.

Palliative care and spiritual care

At the start of the modern hospice movement during the last century, Dame Cicely Saunders formulated the concept of "total pain", which includes the physical, social, psychological, and spiritual dimensions of suffering (Clark, 1999). This concept is one of the foundations of clinical palliative care, which traditionally fosters interdisciplinarity; ideally, a team of different professionals cares for patients with terminal diagnoses by carefully assessing their needs and providing an individual combination of interventions. These disciplines usually include medical treatment for symptoms such as pain or dyspnoea, social care, such as family conferences or home care organisations, psychological treatment for fear or depression, and spiritual care such as consultations with a chaplain or the attendance of religious rituals. The main idea of this multifaceted approach is that the different specialities not only provide their specific services to the patients, but that the professionals have overarching competence and communicate well with each other, so that the patients' needs can be met as they occur (Wallerstedt et al., 2019). Consequently, psychological research in this area has considered the spiritual dimension and has developed models, assessment tools, and training programmes for spiritual care competence directed at health care professionals in general, including psychotherapists in secular societies (Best et al., 2020; Hvidt et al., 2020). In addition to demonstrating the importance of the spiritual

dimension in this field, researchers discuss the different components that spiritual care competence may include. Frick et al. (2019) suggest seven competence factors: (1) perceptual competence, (2) team-spirit, (3) documentation competence, (4) self-awareness and proactive opening, (5) knowledge about other religions, (6) competence in conversation technique, and (7) proactive empowerment competence. They discuss the uneven feeling of professional responsibility for spiritual matters in the different professional groups and the lack of training as a challenge for interdisciplinary health care (Frick et al., 2020).

Religious coping and spiritual struggles

Based on the fundamental work of Kenneth Pargament on spiritually integrated psychotherapy (Pargament, 2011), a number of clinically relevant topics have been identified and explored. The most prominent among these are the concept of religious coping (Pargament et al., 2011; Pargament et al., 1998) and the description of spiritual struggles (Exline, 2013; Exline & Rose, 2005).

The concept of religious coping draws on the general psychological model of stress and coping by Lazarus and Folkman (1984), who describe stress and coping as a process that begins with the interpretation of environmental stimuli (primary appraisal) and the evaluation of available resources (secondary appraisal), if the stimulus is perceived as relevant and potentially threatening. If the resources are considered insufficient, it leads to a stress reaction, which is responded to with different types of more or less efficient and helpful coping strategies, followed by a reappraisal. Thus, the model consists of a series of cognitive and emotional internal and external elements that influence each other. Pargament applies this model to patients who had had potentially distressful experiences in any religious environment, such as a church context or a culture that uses religious communication elements, and/or to evaluate stimuli with references to religious criteria, such as ethical rules or a religious conscience. Relevant resources in this model can be either external, such as support in a faith community or the practice of rituals, or internal, such as hope and trust linked to a faith or a certain image of God. Pargament differentiates between positive and negative religious coping, thus emphasising the fact that religions can contain elements that lead to or aggravate stress, such as controlling religious communities or punitive images of God. Assessment tools have been developed based on this concept (Pargament et al., 2011), and numerous evaluation studies have shown the concept to be health-relevant (Ano & Vasconcelles, 2005).

Spiritual and religious struggles are defined as tensions and conflicts in relation to what people hold sacred and include moral conflicts and questions of ultimate meaning (Pargament & Exline, 2020). These are common in the course of stressful life events and among socially marginalised groups (Pomerleau et al., 2020). Nevertheless, spiritual and religious struggles do not only lead to distress, but can also encourage growth (Dworsky et al., 2013). The clinical relevance lies in a better understanding of the patients' needs as well as in the therapists' sensitivity to such struggles, especially as many patients are hesitant to address them during therapy because of shame or fear of rejection (Exline & Grubbs, 2011).

Meaning making and existential issues in psychotherapy

Especially in secularised societies such as Scandinavia and Western Europe, religion and spirituality can be challenging topics to discuss in scientific psychology (Hvidt & Hvidt, 2019). For some scientists, traditional religion seems to be a cultural hangover from a rapidly disappearing past, making way for individual spirituality (Heelas et al., 2005). Others claim that the classical search for a merciful God, which has been at the core of the Lutheran reformation and the correlated individualisation of spirituality (Klempe, 2020), has become inseparably linked to a search for meaning (Williams, 2020). This search is a personal quest with many consequences for the construction of an identity, the pursuit of success, happiness, and a meaningful life, which can lead to psychological distress for individuals who try to meet these social expectations. Existential issues are part of this quest and can be responded to without referring to traditional religion or individual spirituality, as discussed above. Therefore, meaning making psychology and existential psychology have high clinical relevance and should be considered alongside other approaches in the psychology of religion and spirituality.

Schnell (2009, 2020) proposes a concept that includes a variety of sources for meaning in life, namely (1) *self-transcendence*, which can be divided into vertical self-transcendence, including religiousness and spirituality, and horizontal self-transcendence, such as selfless care for others or general goals beyond one's immediate concerns; (2) *Self-actualization* or personal growth, including creativity, knowledge, and other capacities; (3) *Order*, including cultural traditions and values; (4) *Well-being and relatedness*, which refers to enjoying life's pleasures individually and socially. According to research related to this concept and referring to older theories by Maslow (1970) and Frankl (1972), people more or less fall under three categories; approximately 35% experience existential indifference, 61% experience a meaningful life, and 4 % experience a crisis of meaning (Schnell, 2010). A crisis of meaning could be shown to be statistically linked to clinically relevant factors such as distress and depression, also in Norway

(Sørensen et al., 2019), and treatment based on existential meaning making concepts has been proven to be effective for, for example, patients with chronic pain (Böhmer et al., 2021).

However, existential issues are not only clinically relevant to patients, but also at least equally so to professionals, including psychotherapists. Stotz-Ingenlath (2017) describes the spiritual dimension of the experience of severe psychiatric disorders in clinical practice, such as the existential question of identity and the worth of human life in the course of dementia, or the question of meaning and guilt during depression therapy—it is a challenge for patients, relatives, and therapists to find answers to such challenges. It has been found that the differing world views of psychotherapists have a significant impact on their practice (Peteet et al., 2016), yet the training of psychologists seems to lack a focus on such topics (Reme et al., 2009).

Summary

A significant body of research has shown the clinical relevance of religion, spirituality, and existential questions for psychotherapy. Although some fields of psychotherapy may have a closer affiliation to this dimension, as shown with spiritual care in palliative care settings, religious coping, spiritual struggles, and existential meaning making have been proven relevant in many fields of psychotherapy. From a holistic perspective on mental health (Koslander et al., 2009), this dimension can even be regarded as relevant to any psychotherapy, for both patients and professionals. Thus, by exploring the role of religion and spirituality in Norwegian psychotherapy, this study contributes to a field of theoretical and clinical relevance.

The context

Norway: Christian heritage and secular society

Norway is an example of a Western-European secular culture whose values are significantly influenced by individualistic psychology (Madsen, 2010, 2014). Moreover, Norway also has a strong Christian heritage, with approximately 10 centuries of Christian history (Tveito, 2013), including narratives, values, symbols, and rituals. Despite the decline in conventional religion, it continues to play an essential role. In 2019, 69% of the Norwegian population was still affiliated with the Lutheran Norwegian Church, while 10% belonged to other congregations, with the latter percentage increasing (Statistisk Sentralbyrå, 2019). In the most recent national poll on religion (Norsk senter for forskningsdata, 2019), approximately 50% of the population indicated that they believe in God or a higher power. Modern pluralisation and migration have altered Norway's religious and spiritual terrain, which is shifting from a 1950s Lutheran monoculture to constantly expanding plurality and diversity (Repstad, 2020a).

Secularization theory has attempted to characterise complicated societal changes such as those in Norway, but the results have been inconsistent. With the influence of the Marxist and Freudian perspectives on religion, many scholars have anticipated a steady decrease in the social and cultural relevance of religion and religious institutions, in line with economic progress and growing levels of education (Strulik, 2016). Others favoured a model inspired by economic argumentation, termed the "religious marketplace model". This describes the different interrelationships between politics, religion, and spirituality as a quasi-economic competition in, for instance, contemporary Israel or the United States (Iannaccone et al., 2011). Recent papers have sought to combine these concepts. Dhima and Golder (2021), for instance, relied on large databases from the World and European Values Surveys from 1981 to 2014 to conclude that, in industrialized states, religious attendance gradually decreases while religious beliefs remain. This is due to the fact that the psychological benefits of religious beliefs are free, whereas religious attendance requires time, commitment, and, often, money. Sociological research in Scandinavia (Hvidt & Hvidt, 2019; Repstad, 2020a) describes a corresponding decrease in traditional religiosity and an increasing (spiritual) individualism and pluralism as a cultural phenomenon, particularly among the younger people (e.g. students).

Parallel to secularisation, Norway is experiencing a process of individualisation and diversification as a consequence of the increasing amount of accessible information and physical migration (Taule, 2014). Diversity, including religious and spiritual diversity, is therefore part of the social context of this study, as it affects psychology in theory, clinical training, and practice.

Religiosity gap and university training

During the 1980s/90s, Bergin and Jensen (1990) described a "religiosity gap" between psychotherapists and their clients. They found that psychotherapists were "less committed to traditional values, beliefs, and religious affiliations than the population at large". They discuss possible negative therapeutic effects of a "professional opposition to a spiritual framework" of the clients and demand efforts to bridge this cultural gap. There has been progress on several levels in the academic discussion following this finding.

A first level of differentiation is linked to the definition of religion and spirituality (see above). Bergin already mentioned a "substantial amount of religious participation and spiritual involvement" among psychotherapists that is not necessarily related to traditional religious institutions. Therefore, it is insufficient to inquire about church membership only to measure

the religious or spiritual participation of professionals. Historically and currently, psychotherapists appear to have extremely diversified attitudes to (institutionalised) religion and a frequently complex and conflicted spiritual biography (Blair, 2015; Magaldi-Dopman et al., 2011), and church membership and service attendance may reflect religiosity but not spiritual involvement (Kapuscinski & Masters, 2010). A second level of progress is research on the professional skills that are required to overcome the tension between the clients' existential and spiritual concerns on the one hand and the therapists' personal and professional attitudes on the other hand (Utsch & al., 2017; van Nieuw Amerongen-Meeuse et al., 2018). This competence is closely linked to cultural sensitivity and the therapists' self-reflection and tolerance of uncertainty (Freund, 2017) and requires consideration in both university training and supervision. A third level of relevant research is related to the spiritual match between therapists and clients. Some studies note that matching worldviews are helpful as they can enhance therapeutic trust (Dimmick et al., 2021), while others have shown that it is indeed possible to establish a beneficial therapeutic relationship between client and therapist without excluding the spiritual dimension, even if there is no match in spirituality or religious affiliation between the therapist and the client (Mayers et al., 2007). Regardless, sensitivity is required and therapists have to beware of ethical boundaries and manage the challenging task of spiritual self-disclosure (Barnett & Johnson, 2011).

Guidelines for psychotherapy have included consideration of professional sensitivity for diversity for many decades (American Psychological Association, 2003). Psychological candidates are required to possess cultural competency after completing their university programme, which has to include a combination of knowledge, attitude, and abilities. This involves having knowledge of the significant disparities in individual life circumstances, customs, and beliefs, respecting these differences, and being aware of one's own prejudices (Kubokawa & Ottaway, 2009). Religion and spirituality are included in the list of conceivable diversities, alongside social, cultural, ethnic, and gender diversity in both the United States of America and Europe (American Psychological Association, 1990; Deutsche Gesellschaft für Psychotherapie, 2016; Norsk Psykologforening, 2020). Some researchers, such as Plante (2014) and Plante (2014); Sperry (2014) emphasise that any spiritually oriented psychotherapy has to be culturally sensitive to meet the ethical standards of professional psychotherapy.

For a variety of reasons, it appears to be difficult to achieve diversity sensitivity in psychotherapy in general, and particularly sensitivity in religious and spiritual questions, first, because the diversity of professional psychotherapists does not always reflect the diversity of

the community they serve—psychology students and practitioners are often from privileged backgrounds, while patients are considerably more diverse—and, second, because effective training in cultural sensitivity requires trained teachers and supervisors. However, for the most part, teachers also lack the appropriate training (Turpin & Coleman, 2010). Although multiculturalism has become an acknowledged key value in psychology, practitioners, instructors, and researchers seem to be a bit hesitant, particularly in regard to religious diversity (Plante, 2014). This also seems to occur in Norway, where both patients and practitioners report a lack of confidence in appropriately addressing existential and spiritual questions in psychotherapy (Holmberg et al., 2017; Ulland & DeMarinis, 2014). In a nationwide survey, Reme et al. (2009) showed that students' expectations of learning about religion were far from being met in university teaching.

The low representation of this issue in the literature and in university education in the United States has been criticised (Hartmann et al., 2013), and there is an ongoing debate on how well recommendations have been implemented (Daiches, 2010; Turpin & Coleman, 2010). However, textbooks on the subject have been available since the previous century, such as Fukuyama (1999) or, more recently, training material such as that by Gill and Freund (2018) or, in the Norwegian context, by Danbolt et al. (2014). However, the degree to which these texts are being used in education is still unknown.

Research questions

The overarching question of this thesis is ***"which role do religion and spirituality have in Norwegian psychotherapy?"*** This question is addressed from three different perspectives in one qualitative and two quantitative studies. Describing the role of religion and spirituality in Norwegian psychotherapy can (and should) be done in a myriad of ways. Many studies in this field, internationally and in Norway, focus on patients by measuring treatment outcomes; correlating personality factors, religion and spirituality, and mental health; or testing the validity of general findings for specific religious groups or in different cultures. However, the perspective of the therapists or health care professionals in general regarding religion and spirituality has received less attention. Questioning those who practice health care about the role of religion and spirituality can provide important information, perhaps not so much regarding the effect on patients, but about their experiences and obstacles and the possibilities in clinical practice. One factor in the choice of the research question is a desire to contribute to the discussion about the understanding of psychotherapy and its development. This thesis is an attempt to illuminate the clinical reality in Norway today, provide an analysis of the status quo,

and raise questions about what the role of religion and spirituality could and should be. Recent studies done in Norway included family therapists, social workers, and general mental health professionals (Frøkedal et al., 2019; Furman et al., 2007; Holmberg et al., 2017). However, the relationship of Norwegian psychologists with religion and spirituality has rarely been studied. Therefore, focusing on psychologists as opposed to general mental health care practitioners and involving psychologists as experts as well as students (future psychologists) seemed to be a meaningful choice.

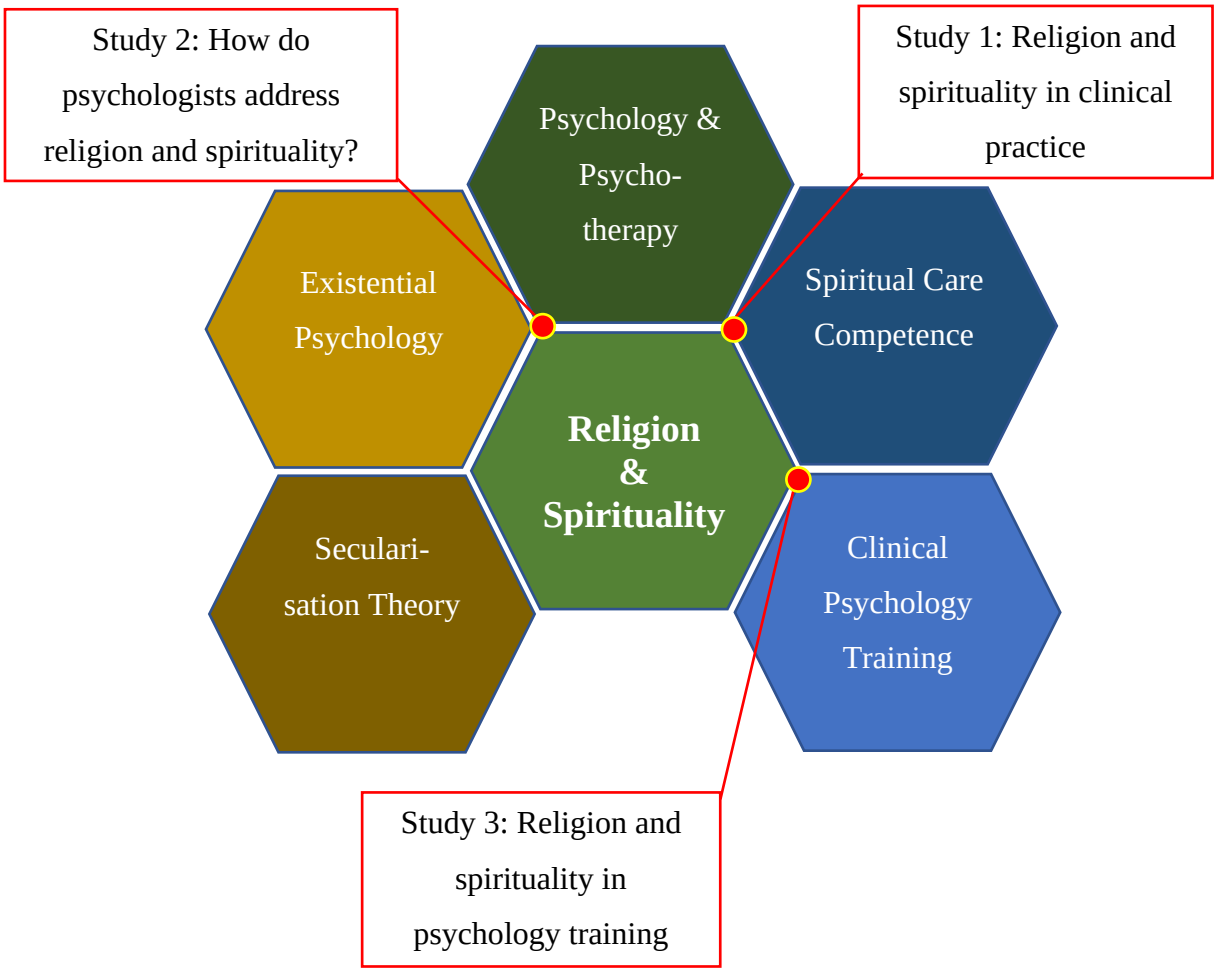
The overarching question was divided into three subordinate questions:

- First, exploring the status quo, ***"To what degree are spiritual and religious topics part of clinical psychological practice in Norway?"*** Spiritual care competence was used as a measure to compare psychologists to other mental health care workers.
- Second, drawing on experts' narratives, ***"How do psychologists understand and address spirituality and religion in therapy?"***
- Third, focussing on future psychologists, ***"What is the role of spirituality and religion in Norwegian university psychology training?"*** This study is a replication of a survey study done in 2005 and mainly includes the views of Norwegian psychology students.

In the discipline of the psychology of religion and spirituality, research on psychotherapy is one of the many fields of interest. Figure 1 displays the position of this thesis in this field, including the three subordinate research questions addressed in the three separate studies.

Figure 1

Positioning of the PhD project's research questions in the scientific context



Study design, methodology, and ethics

Research into the intersection of psychotherapy, religion and spirituality has several challenges. One such challenge is the dominance of US research in comparison to research from other parts of the world where different cultures prevail, including different religions and world views. The risk of WEIRD truths (research based on data from Western, educated, industrialized, rich and democratic societies) (Henrich et al., 2010) as basis for further research is obvious. Studying cultural phenomena such as religion and the understanding of psychotherapy, however, needs a balanced approach that considers a larger variety of religions, spiritualities, and world views. Newson et al. (2019) suggest that the especially the psychology of religion should embrace methods that ensure diversity and are transparent as to the origin of the data and the applicability range of the findings. Another challenge is the interdisciplinary nature of the topic: "Spiritual/existential competence in psychotherapy" touches, amongst others, on psychology as well as theology/religious studies and sociology. These subjects, however, have quite different scientific traditions that are not necessarily compatible.

The changes in terminology within the subject of the psychology of religion, which correlates with the increase in multicultural viewpoints, exemplify these challenges. The terms "religion" and "religiousness" were used by the pioneers in the area of psychology of religion in early studies (James, 1902 (1985)), pertaining mainly to the United States of America, with the Christian faith serving as the primary source for solutions to existential concerns. In later years, the term "spirituality" was included in research (Pargament, Mahoney, Shafranske, et al., 2013). This was done in the light of the growing diversity in spiritual perspectives in Western nations, as well as the need for doing research on a global scale. In more recent research done in Norway, the term "existential meaning making" has been used (Ulland & DeMarinis, 2014), thus widening the field and framing it differently; religion and spirituality became two possible ways of responding to existential questions in addition to a secular approach or even indifference (Schnell, 2020). It is clear that transferring knowledge from one time to another and from one discipline to another must be done carefully.

To address at least some of the mentioned challenges, this thesis is designed as a mixed-methods study, and draws on the idea of crystallisation (Ellingson, 2009) to shed light on different aspects of one question.[1] In the following, I first present the three studies separately, including

[1] For a more thorough explanation of the concept of crystallisation, see the discussion of mixed-methods validity, p.43.

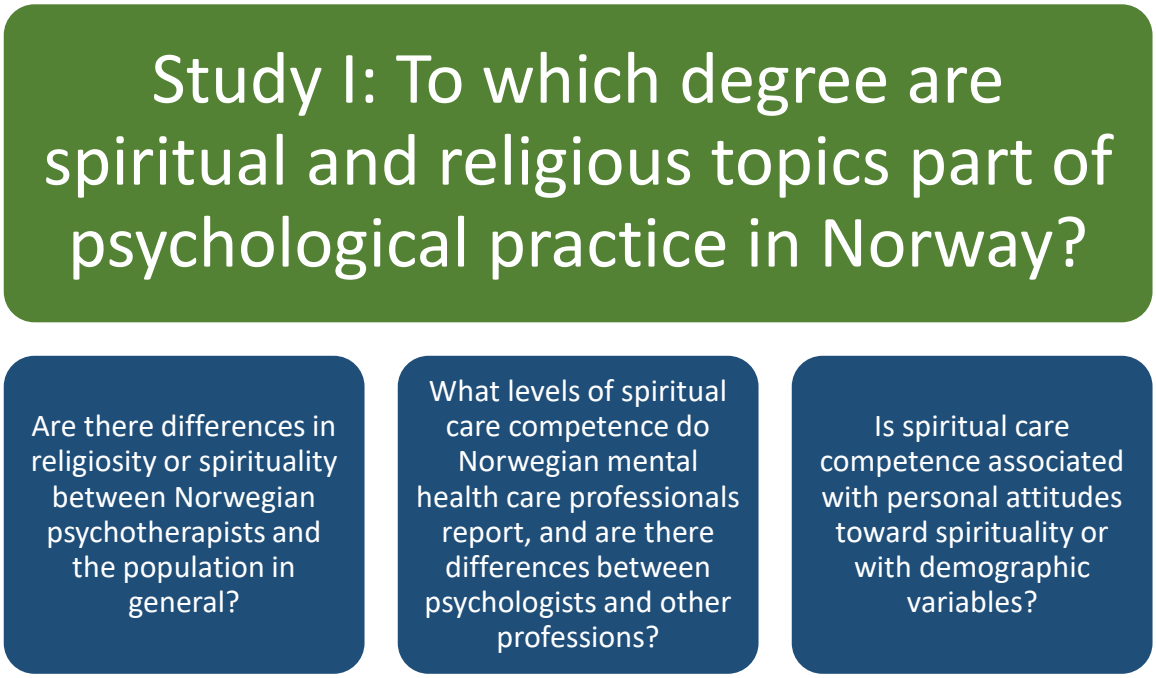
a methodological reflection. The chapter draws on the published articles that are part of this thesis (Mandelkow, Austad, et al., 2021; Mandelkow, Frick, et al., 2021; Mandelkow & Reme, 2022) but provides additional methodological information and reflects on aspects that were not included in the restricted word limit of the journals. The next chapter discusses general methodological and epistemological aspects of this mixed-methods approach, before I finally reflect on one central ethical aspect, the role of the researcher's spirituality in research on spirituality.

Study one: methodological reflections and validity analysis

To answer the research question and its subordinate questions (Figure 2), I chose a survey on spiritual care competence in clinical mental health care and invited health care professionals from three Norwegian clinics to respond.

Figure 2

Research Question and Subordinate Questions Study I



Choice of instrument

To answer the question to which degree and in what way religious and spiritual topics are included in psychological practice in Norway, a self-report questionnaire to measure spiritual care competence is a suitable choice, as the concept of spiritual care encompasses both the "if"

and the “how” of religion and spirituality in health care. Current discussions suggest that knowledge, skills, and attitudes are core components of this competence (Oxhandler & Pargament, 2018).

The Norwegian version of the Spiritual Care Competence Questionnaire (SCCQ), developed by Frick et al. (2019), was used to operationalize the concept “spiritual care competence”. The SCCQ contains questions about the degree to which respondents feel confident to address a variety of areas pertaining to spiritual, religious, and existential concerns in their work. Among the numerous scales that relate to this issue, the SCCQ seems to be the best suited to a study of a range of spiritual care-relevant factors in a secular society. There are a number of different assessments for spiritual care competency, the majority of which are in English and many have been developed for a specific profession (McSherry et al., 2002), specific clinical settings (Gordon & Mitchell, 2004), the evaluation of training (Van de Geer et al., 2018), or they are based on a specific religious background (Sedigheh et al., 2012). Some of the suggested scales include a balanced range of parameters and demonstrate strong validity and reliability, but are based on a small and homogeneous sample (van Leeuwen et al., 2009). A detailed discussion of the different scales can be found in a publication by Frick et al. (2019). The SCCQ, which has been endorsed by the European Association of Palliative Care (Best et al., 2020), is the only scale that has been validated with a larger sample (N = 717), including several groups of health care professionals and many languages. In addition, it encompasses attitudes, knowledge, and skills in the concept of spiritual care competency and analyses the spiritual and/or religious engagement of the participants. However, this questionnaire was not yet available in Norwegian when the study was planned.

The Spiritual Care Competence Questionnaire (SCCQ)

The questionnaire consists of two parts, first, a brief introduction and request for some personal data. Religious/spiritual engagement is assessed by membership in a religious community (as an organisational and social feature of religiosity), "active believing" (as an attitude), and "prayer/meditation" (as a private form of religious/spiritual engagement). The SCCQ is comprised of 41 items with a 4-point Likert scale response field, ranging from "I strongly disagree" to "I strongly agree" and two free-text responses. This study measured spiritual care competence on seven factors with the use of 26 statements: (1) perceptual competence; (2) team-spirit; (3) documentation competence; (4) self-awareness and proactive opening; (5) knowledge of other religions; (6) competence in conversation technique; and (7) proactive empowerment-competence. The German SCCQ scale has been thoroughly tested for validity

and reliability by its developers (Frick et al., 2019), and showed good internal consistency of these seven factors (Cronbach´s α ranging from 0.73 to 0.86). The underlying structure was verified by confirmatory factor analysis (SEM).

Validity and reliability of the Norwegian version of the SCCQ

A comparison of the original German scale and the Norwegian version of the SCCQ showed good validity and reliability. An explorative factor analysis resulted in seven factors (see below), and the structural equation modelling confirmed the model with CFI (comparative fit index) = 0.96, TLI (Tucker-Lewis index) = 0.95, RMSEA (root mean square error of approximation) = 0.04, and SRMR (standardized root mean squared residual) = 0.05. Several steps were taken to estimate whether the instrument's high quality would be preserved in the translation process and use in a slightly different cultural environment:

1. A thorough translation process
2. A Cronbach's alpha estimate of the given factors
3. A principal component analysis with the given number of factors, including parallel analysis
4. A structural equation modelling

The German scale was translated into Norwegian using forward and backward translation by native speakers in both Norwegian and German and informed as well as uninformed translators, and a meeting was held for cultural adaptation (Beaton et al., 2000). Especially the key words "spirituality, spiritual, religious believing, faith," and so on needed some discussion to avoid misunderstandings. For example, to ensure an open understanding of this dimension that includes spiritual, religious, and existential elements, we decided to ask staff to participate in a study of "eksistensiell kompetanse", using the term that is the most neutral in Norwegian.

The Cronbach's α analysis for the German scale ranges from 0.73 to 0.86. The corresponding analysis for the Norwegian translation resulted in values ranging from 0.70 to 0.84, which can be considered satisfactory (Table 1).

Table 1:

Cronbach's α for the German and the Norwegian scales

Factor	1 (perception)	2 (team-spirit)	3 (documentation)	4 (self-awareness)	5 (knowledge)	6 (conversation)	7 (empowerment)
Cronbach's α German scale	0.82	0.81	0.84	0.83	0.73	0.86	0.79
Cronbach's α Norwegian scale	0.76	0.76	0.79	0.76	0.72	0.84	0.70

For a more accurate estimate, I performed a principal component analysis (PCA) on the data. The sample size is smaller than in the original German analysis and the focus was only on mental health institutions, which narrows the field somewhat. Still, with 26 items involved and 262 participants, a ratio of 1 to 10 was obtained, which is considered sufficient (Pallant, 2005). The suitability of the data for factor analysis was assessed by examining the correlation matrix, which showed many coefficients of 0.3 and above and by checking the Kaiser-Meyer-Oklin value, which was 0.86, higher than the recommended 0.60 (Tabachnick et al., 2007). Barlett's Test of Sphericity (Bartlett, 1954) was significant, supporting the factorability of the correlation matrix.

The PCA showed eight components with eigenvalues that exceed 1. To estimate the comparability of results, the number of factors was manually set to seven, according to the original German scale, and the same rotation method was used (Oblimin).

Although the inspection of the scree plot (Figure 1) might suggest a smaller number of components, and the results of a parallel analysis also confirmed a number of four components (Table 2), it was decided to adhere to the number of seven factors to ensure the comparability of the results, following the Kaiser criterion (retaining components with an eigenvalue higher than 1), to explain between 30.5% and 3.8% of the variance. Accumulated, the seven factors explain 65,2% of the variance.

Figure 3

Scree plot PCA

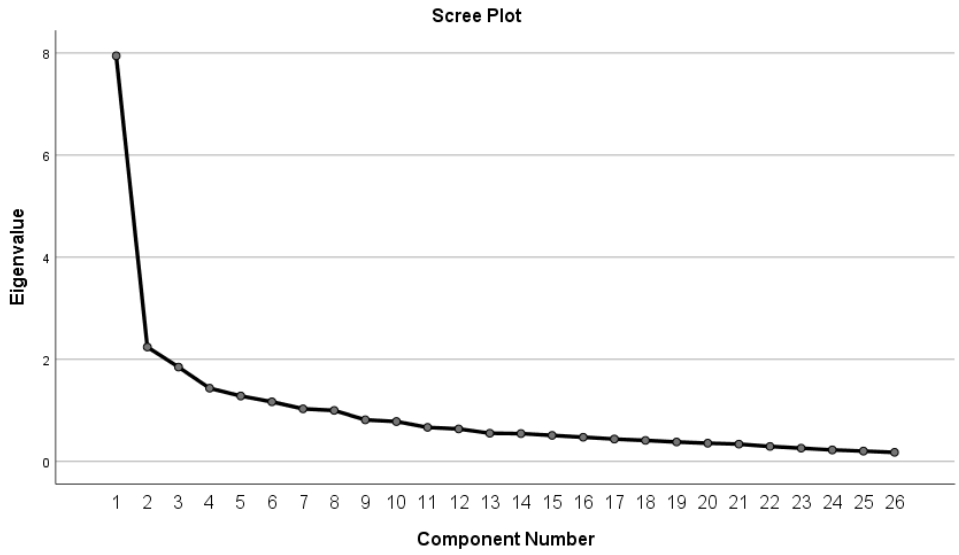


Table 2

Comparison of eigenvalues from PCA and parallel analysis

component number	actual eigenvalue from PCA	criterion value from parallel analysis	Recommended decision
1	7.944	1.626	accept
2	2.240	1.527	accept
3	1.848	1.454	accept
4	1.434	1.390	accept
5	1.281	1.337	reject
6	1.167	1.286	reject
7	1.030	1.239	reject

The component correlation analysis showed no correlation above 0.30. After Oblimin rotation, we could compare the results from the German sample and the original scale with ours (Table 3). There is a considerable concordance between the two. The high loading of factor 7 variables on factor 1 is not unexpected, given the high correlation between the two already in the German data (Frick et al., 2019).

Table 3

Comparison factor analysis German and Norwegian sample

Item number and short version[2]	**Corrected item-scale correlation**		**Factor corresponding to the original analysis, loadings from the German (ger) and Norwegian (nor) sample**													
			1 (perception)		2 (team-spirit)		3 (documentation)		4 (self-awareness)		5 (knowledge)		6 (conversation)		7 (empowerment)	
	ger	nor	ger	nor	ger	nor	ger	nor	ger	nor	ger	nor	ger	nor	ger	nor
(2) seeing relatives' needs	.575	.552	.851	.482												
(1) seeing patient's needs	.621	.628	.831	.461												
(7) exist. needs without religion	.597	.588	.712	.371												
(8) talking about exist. needs with irreligious	.545	.719	.590	.591												
(28) enduring patients' pain	.368	.314	.526													.577
(14) team about spir.	.658	.860			.775	.818										
(15) team about personal spir.	.549	.792			.746	.783										
(12) team about patients' spir.	.620	.697			.738	.561										
(17) team rituals	.341	< .3			.661											.788
(13) spir. Institution	.465	.796			.531	.769									-.462	
(4) measures for spir. Needs	.470	.867					.891	.867								
(3) anamnestic instruments	.505	.887					.863	.907								
(5) documentation	.463	.696					.705	.599								
(48) deepen personal spir.	.508	.825							-.833	.845						
(49) seminars	.551	.731							-.735	.735						
(30) personal spir. impacts	.525	.708							-.698	.678						

[2] Shortened, approximate translation for identification purposes by the author

(43) opening room	.681	.551					-.537	.404						
(42) asking patients about spir.	.624	.610					-.519	.513						
(38) other religions	.335	.860							.887	.849				
(39) other religions' needs	.364	.863							.824	.844				
(20) talking about religion	.539	-.870									.774	-.855		
(19) talking about exist.	.576	-.909									.749	-.903		
(24) partici-pation rituals	.479	.769	.747										-.801	
(25) spir. in therapy	.591	< .3	.637										-.628	
(35) adequate surroundings	.624	.448											-.569	.333
(26) foster reflexion	.695	< .3	0,461										-.533	

To analyse the fit of the given model on the Norwegian data, we also produced some central model-fit indices by using the SPSS2LAVAAN programme (Busching, 2016) and the SPSS R-plug-in. There is some expert discussion on which indices to consider and which cut-off values to use, but there seems to be some consensus on RMSEA and SRMR as being central (Kenny, 2015). The RMSEA for our data is 0.071, which some experts consider between a good and mediocre model fit (MacCallum et al., 1996). The SRMR is at 0.075, which is just under 0.08 and, therefore, considered a good fit according to some experts (Hu & Bentler, 1999). These numbers suggest that the model fit is not as good as in the data from the German sample (RMSEA = 0.04, SRMR = 0.05, (Frick et al., 2019), but the model was, nevertheless, confirmed.

Overall, I concluded that the Norwegian translation of the German SCCQ scale measures spiritual care competence in a reliable way and that the results are comparable, with consideration of the smaller sample size and the focus on mental health care in this thesis.

Participating institutions

All members of the medical staff working in the mental health wards at two different hospitals and one psychiatric centre were asked to participate in the study. All three institutions provide treatment to patients with mental health problems, with a wide range of diagnoses, and are, as

such, representative of Norwegian health care. In addition, they have a special position toward religion and spirituality:

The psychiatric clinic located at *Sørlandet Sykehus* is the most important provider of mental health care in Southern Norway. It is a secular organisation according to legislation and presents itself accordingly. However, due to its geographic position in the middle of an area with an unique Christian heritage, it presumably has a high number of religious clientele and personnel (Løvland et al., 2008) .

Modum Bad is a centre for psychiatric treatment and psychotherapy that serves the whole country. It has an ecumenical and diaconal history and is recognised as an ordinary hospital by the Norwegian health care system. It was founded on Christian principles and still has strong connections to different church institutions. In addition to the regular treatment of mental health patients, there is a specialised research section at Modum Bad that investigates the role of religion in psychotherapy (Staalsett et al., 2010).

The *Diakonhjemmet* mental clinic is a hospital in the Norwegian capital, Oslo. In its bylaws, Diakonhjemmet cites its old diaconal heritage and charity as fundamental values, so it could be seen as a Christian institution. Moreover, it states that charity must be expressed in a suitable, contemporary manner, such as via high-quality medical care (Diakonhjemmet, 2019), thus expressing secular values, and both staff and patients are mainly from Oslo, which is Norway's most secular region.

Given the characteristics of these three institutions, it could be assumed that religious or spiritually active staff would be overrepresented in this sample compared to Norwegian mental health care overall. This was intentional, as the phenomena I wanted to investigate are linked to open concepts such as religion and spirituality, and the study design was selected to secure sufficient statistical power for comparative analyses. A targeted selection of institutions would increase the probability of having religious attitude and spiritual activity represented in the data, so that it would be possible to compare, for example, religious psychotherapists to less religious ones.

Procedural aspects

Two aspects became especially interesting during the process of data collection. First, when I contacted responsible leaders who could distribute the paper questionnaires to the staff, I regularly received the feedback that the words "religion" and "spirituality" in the Norwegian translation could be interpreted differently from one person to the next. Regarding the research

intention, the leaders were therefore provided with an instruction that stated the open definition of the words as "anything participants would understand as related to a faith, the existential, or higher powers of any sort". Nevertheless, it cannot be assumed that this definition was communicated equally on all wards.

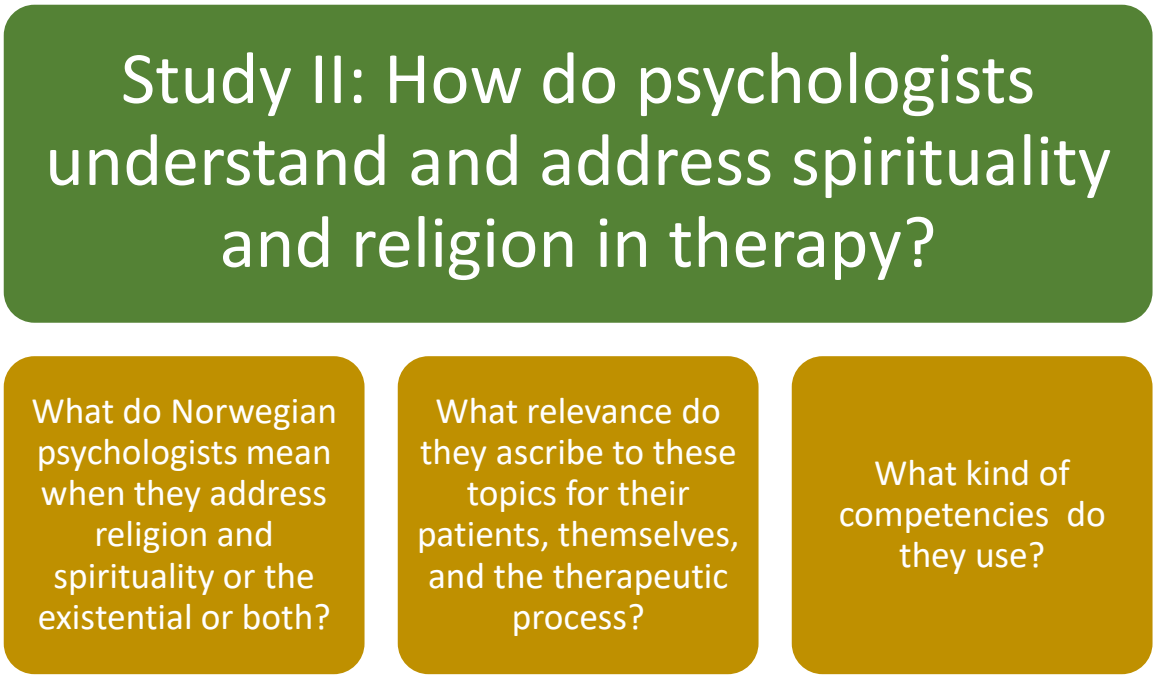
Second, there were special conditions for the data collection in the Oslo clinic *Diakonhjemmet*. Due to new data security regulations in the clinic, the administration insisted on the physical presence of a research team member who could collect the questionnaires directly after completion. Time for the completion of the questionnaire was set aside during team meetings. This led to a much higher response rate in this clinic compared to the other two and a lower selection bias caused by staff who would prefer to not participate in a survey connected to religious topics—the presence of a researcher makes not participating more difficult compared to when a questionnaire is just distributed and then collected later, despite the fact that participation was strictly voluntary. In addition to this effect, the researcher could introduce the questionnaire with a consistent open definition of religion and spirituality. These circumstances must be considered in the interpretation of the results.

Study two: methodological reflections

To answer the research question and its subordinate questions (Figure 3), I conducted a content analysis of eight expert interviews on spirituality in psychotherapy.

Figure 4

Research Question and Subordinate Questions Study II



To gather material, I conducted eight semi-structured interviews with licensed psychotherapists, meeting them personally and obtaining audio recordings, which were later transcribed with the help of a native Norwegian speaker to avoid misunderstandings based on language issues, such as Norwegian dialects. The selection criteria to find the answer to the subordinate research question of how religion and spirituality is addressed and understood in therapy were quite narrow. I exclusively asked psychologists who were experienced in integrating spiritual/religious/existential questions in their work and had reflected on the topic in publications, theses, or public discussions. Therefore, the data collected does not include the experiences and attitudes of psychologists who are critical of or do not address religion and spirituality at all—this aspect of the research topic is in the scope of study one. Nevertheless, I aimed at a varied sample in the group of psychologists interested in the intersection of therapy and religion and spirituality by contacting different institutions and private practitioners and requesting participation and recommendations of other colleagues. Of 16 invited professionals, eight accepted. The final group of participants were diverse in gender, age, religious standpoint,

professional speciality, and therapy setting, including individual therapy, group therapy, or institutional treatment. The sample includes persons who identify as active Christians, others who draw on their Christian socialisation in Norway, agnostics, and some who were interested in Buddhist spirituality and mindfulness. There were no Muslims, Jews, or other minority religions represented in the sample, so the data does not include an extended religious diversity. The interviews were designed as a combination of "expert interviews" (Meuser & Nagel, 2009), focussing on the understanding and therapeutic navigation of religious and spiritual matters, and an open inquiry, following the general recommendations for qualitative research (Kallio et al., 2016).

Corresponding to the interview design, the analysis combined the two main strategies outlined by Braun and Clarke (2006). First, a theoretical analysis based on given categories was performed. This means that the participants were regarded as experts who contributed to the exploration of the Norwegian situation with their knowledge and experience. Second, an inductive analysis was performed that searched for common topics in the individual answers. It attempted to find aspects of the topic that had not transpired before. The main findings in the qualitative study are presented in the next chapter, together with a summary.

Quality

To evaluate the quality of this qualitative research, I followed the criteria suggested by Tracy (2010), who presents a model with eight markers for quality, to discuss both the ends and the means of qualitative research.

Worthy topic

The relevance and significance of the given research question is an interesting aspect, as some clinical psychologists regard religion as an outdated topic that is becoming ever more redundant as secularisation develops in modern societies, even though research has come to different conclusions (Dhima & Golder, 2021). As discussed in the introduction, clinical psychological practice seems to lack focus on the existential dimension. Research on patients' needs, however, shows that there is a growing demand for spiritual and existential orientation, also in psychotherapy. Therefore, the fact that a majority of those responsible for the training of psychologists may doubt the relevance of this study (Reme et al., 2009; Vieten et al., 2013), could actually be one of the strongest arguments for its relevance.

Rich rigor

Considering Tracy's demand for rigor, the qualitative part of this study must be considered small scale compared to what is deemed desirable. It does not include therapists with other than Christian backgrounds or therapists who are openly critical about spiritual openness in therapy, and it does not differentiate between therapeutic schools or areas of specialisation. I did not return to the respondents or find new interview partners to gather more profound data on the findings of a first analysis. The limited time frame of a PhD project may be an explanation for the majority of these shortcomings, but an explanation does not increase quality. However, the variety of backgrounds, ages, genders, and specialisations, as well as the 150 pages of text and the variety of topics discussed in the interviews may lead to a sufficiently rigorous study. In addition, the qualitative data do not stand alone in this thesis but supplement the quantitative analyses and are supplemented by them.

Sincerity

According to Tracy, the most important ingrediencies of sincerity in qualitative research are self-reflectivity and transparency. Nevertheless, self-reflexivity is one of the core competencies of psychotherapists, and transparency, as my analysis has shown, is one of the main challenges related to spirituality in therapy. Therefore, this quality criterion deserves additional attention, and I dedicated an extra chapter in this thesis to "spiritual self-disclosure", a concept that incudes self-reflexivity. On my side, there has been constant reflection on my motives for this study, my positioning, and the effects these factors may have on my respondents and my interpretations. On the one hand, I attempted to answer the questions about meaningful reflexivity in research suggested by Lazard and McAvoy (2020). Transparency, on the other hand, is more limited due to the limited space that can be allotted for self-reflection in an interview situation and a published article.

Credibility

As standard quality criteria from quantitative research do not apply to qualitative research easily, credibility in my study relies on thick descriptions of the relevant themes found in the data and on crystallisation. The selection and presentation of themes in the analysis and the following article are mainly a product of an engaged dialogue between me as main author and data-collector and my two co-authors. They continually asked for better quotes to support the claims, and the necessity to adhere to the word limit of the journal led us to choose the most expressive quotes, which led to thicker descriptions. As for crystallisation, the study relies on relevant studies that emphasise patients' experiences of religious and spiritual matters in

therapy as well as international perspectives. As part of the entire mixed-methods PhD project, the credibility of the interview study is increased by the corresponding results of the two quantitative studies that highlight different aspects of the same overarching research question (see discussion of results).

Resonance and significant contribution

As a researcher's personal excitement about a special topic does not necessarily correlate with its impact on possible audiences, the criteria of resonance and contribution may be best evaluated by the reactions to the published article, to oral presentations, and to newspaper interviews about the research.

My desired key readers would be psychotherapy researchers and members of universities who make decisions about curricula in psychology. Resonance from this side, however, is scarce. Instead, interest emanated from churches, religiously interested newspapers, or organisations such as the "Council for Religious and Life Stance Communities in Norway". However, the latter organisation is not so much interested in scientific details, but rather in results that can be used in political debates. At conferences, supportive resonance tended to come from either spiritually interested psychologists who feel that this dimension is underrepresented, or from non-psychological professionals who want to see a change in psychologists' general attitude, such as frustrated hospital chaplains who feel that the existential dimension is neglected in health care. This resonance emphasises that a significant contribution has not (yet) reached those who should be reached. Further publications in relevant media and participation in public debate may change that.

Ethical

In addition to procedural ethics that protect the personal data of my participants and for which adherence is ensured by following official guidelines (NESH, 2021), there are no obvious ethical issues that may stem from involvement with vulnerable groups or delicate political or social conflicts. Nevertheless, there are some situational and relational ethical aspects to consider. For a more detailed discussion, see below in the ethical reflections section.

Meaningful coherence

The study may be criticised for claiming a critical realist approach and then using experts as a source of information. It could be argued that, in a public discourse, "experts" are what "facts" are in positivist research, as they traditionally stand for "true knowledge", or at least have a complicated position in a post-positivist epistemology (Grundmann, 2017). Nevertheless,

Benton and Craib (2011, p. 122) describe critical realism as an approach to knowledge that uses depth instead of superficial and potentially misleading empirics to discover truths about a reality that is in principle accessible and not a mere social construct but not at the disposal to complete empirical description either. Therefore, listening to experts with in-depth experience in this specific field of study makes sense in the epistemological frame of critical realism. In the context of this PhD-project as a whole, the voices of the experts add an important perspective in addition to those of the general mental health practitioners and psychology students in the two survey studies. The challenge of merging potentially different epistemologies in a mixed-methods study is discussed separately after the reflection on the methodology of the third study.

Study three: methodological reflections

To answer the research question and its subordinate questions (Figure 5), I conducted a nationwide survey among university psychology students on religion and spirituality as part of clinical psychology training. In addition, key personnel at the four university faculties were requested to identify relevant courses in their curriculum, and national survey data were used for comparison.

Figure 5

Research Question and Subordinate Questions Study III

The study is a replication of a study conducted by Reme et al. (2009) with data from 2005, thus allowing for special methodological possibilities and challenges, which I discuss in the following.

The survey

The 2005 survey has 42 questions, the majority of which have four Likert-scale answer alternatives. In the replication study, the questionnaire was evaluated and altered slightly (see appendix), based on the relevance of and item responsiveness in the 2005 study. In addition, several elements were omitted due to data security concerns. An explanation of "religion" and "religiosity" is provided at the start of the survey. The first section comprises basic demographic information, such as gender and study location. The participants were then required to respond to 14 questions on their views, opinions, and religious affiliation. The questions fall into one of four categories (Table 4).

Table 4

Survey Categories and Example Items

Category	**Number of survey items**	**Example items**
Attitudes towards religion as a part of psychological training	5	I think that the spiritual dimension is just as important for being human as the mental and physical dimension and, therefore, it is important in psychology.
Experience of attitudes in psychology towards religion and religious people	3	I think that psychology has a differentiated approach to religion. I have experienced that religious people have been made fun of in lectures.
Religion as topic in lectures	2	In which form have you experienced teaching on religion in psychology (lecture, seminar, etc.)?
Religious identification	4	How often do you attend religious services or other religious meetings?

The distinction between "religion" and "spirituality" and their relationship to the concept "culture" is the subject of an ongoing debate (Eckersley, 2007; Kim-Prieto, 2014; Paloutzian &

Park, 2014), even more so when it concerns changes in meaning caused by translations (Løøv & Melvær, 2014; Stifoss-Hanssen, 1999). In both the 2005 study and the replication, the intention was to elicit a wide range of interpretations. Following Richards and Bergin's definition that "religion encompasses ideas, behaviours, and sentiments that are often expressed both institutionally and personally", the poll was presented with this description (Richards & Bergin, 1997) in both the 2005 and 2020 surveys.

Replication quality

In a fundamental article on replication studies in the social sciences, Schmidt (2009) notes that "replication" is a surprisingly underdefined term, both practically and epistemologically. His definition of a *direct replication* includes the use of identical experimental materials and usually refers to controlled laboratory conditions. The wider concept of *conceptual replication* means the "repetition of a test of a hypothesis or a result of earlier research work with different methods" (p.91). Even though the present study may be somewhere in between those two, there are still some limitations that should be considered.

Practically, the study used the same basic measurement tool, a survey designed to explore students' attitudes and experience regarding religious topics in clinical psychology training. However, some items were eliminated in the replication study, partly because they had not produced significant results in the first study or because they were no longer considered relevant, and partly because new data security restrictions prohibit the implementation of certain questions. Furthermore, the technology used was different in the second study. Instead of distributing a webpage-based survey via e-mail, *Nettskjema* was used, which is a newer tool for designing and conducting online surveys. Nettskjema was created and is managed by the University Information Technology Centre (USIT) at the University of Oslo, and it is tailored to comply with Norwegian privacy laws. It is simple to use, and responders may enter responses using a web browser on a computer, smartphone, or tablet—which means that the conditions under which the questions were answered were probably quite different.

However, even if the procedures were regarded as sufficiently similar to regard the study as a replication, there are still epistemological considerations. Schmidt argues that even the most controlled experiments "accumulate history" (p.92), so that the knowledge obtained can never be exactly the same. In the case of this study, the most obvious historical alteration was in the choice of words, which caused a research dilemma: A replication would require unchanged wording in the survey. At the same time, in the 15 years since the first study, the use of the

words “religion” and “religious” has changed slightly (Repstad, 2020a), so that the same words in the survey most certainly would have different connotations. Several free text answers from participating students confirmed this retrospectively; students complained about the narrow wording and the impossible task to scale “religiousness”, which they do not experience as a stable trait but as a changing personal response to their surroundings. However, it was impossible to determine how to change the wording in a way that would allow for completely comparable results. Therefore, the original wording was retained. Collecting data during the Covid-19 pandemic might also alter the situation, in the sense that both the perception of a digital survey and the meaning of religiosity might have been impacted by mainly digital teaching and the experience of isolation among students during that time (Bonsaksen et al., 2022).

Thus, the term “replication” must be used carefully. However, it can be applied to the general study design. Students from the same four universities were invited to answer the same set of questions, and a similar number of students responded.

Representativity

In a meta-analysis of online surveys covering 20 years of research, Van Horn et al. (2009) found a general increase in web-based surveys in psychological research with a correlated decrease in the response rate. Considering the exponential growth of digital media over the last 10 years, including quality management and customer satisfaction surveys, it seems viable to conclude that research survey response rates are more impacted by general participation fatigue today than 15 years ago. In a more recent systematic review of online response rates in counselling research, Poynton et al. (2019) indicate an average response rate of 34.2% (SD = 22.6).

These numbers, in addition to the polarising effect that questions about religion might have on Norwegian students (Lundby, 2016), illustrate the danger of selection bias in the sample. There are at least two possible scenarios; a survey about religion could attract students who have a positive attitude towards religion, or it could appeal to students who want to engage in the discussion, with positive or critical attitudes. Either way, there would be a risk of bias, as the more critical or moderate opinions may be missing.

Several measures were instituted to protect representativity. First, the invitation to the survey was formulated in an academic, nonpolarizing way to appeal to any psychology student. Second, an incentive was offered to make participation in the survey attractive, also to students who may not be thematically engaged. The incentive, a participation in a raffle to win a gift

card worth NOK 1,000, corresponded to one used in the 2005 survey. Third, a broad range of communication channels was used to increase the response rate, including social media, reminder e-mails, and personal invitation through university teachers. Fourth, participants were asked about their personal religiosity, and these responses can be used to make an assumption about a participation bias when they are related to corresponding numbers in the general Norwegian population.

National norm data

Another way to improve the interpretability of the data was to include an additional level of comparison in the analysis. Some of the questions (membership in religious groups, personal religiosity, and service attendance) are worded in accordance with questions from national polls on religiosity to facilitate a direct comparison between the students and the Norwegian population as a whole. The national surveys are a component of the International Social Survey Programme (ISSP), and the findings are publicly available via the Norwegian Centre for Research Data (NSD). These sources have high data quality. However, the years of data collection on a national level do not exactly match the years of data collection among the students. The 2005 sample can be compared to the national data from 2008, while the 2020 sample is linked to the national data from 2018, so the comparison is not precise. Nevertheless, it is possible to draw general conclusions about representativity by using the same questions on samples from the two time periods (2005/2008 and 2018/2020) and comparing them on sociodemographic characteristics, such as religiosity and membership in a religious group.

Curricula information

Exclusive data collection among students can be criticised for being one-sided. Indeed, extending the survey to university psychology teachers would have been methodologically favourable, but was not possible in the scope of this thesis. However, I attempted to balance this one-sidedness at least partially by gathering information on clinical psychology curricula at the relevant Norwegian universities through searching websites and asking responsible university staff. A summary of the results, which largely match the students' reports, can be found in Table 5.

Table 5

Coverage of Religion in the Clinical Psychology Training Programme at Norwegian Universities, Faculty Reported (Study Points and Content)

University	Course topic and study points	Religion and spirituality in the course
UiB (Bergen)	Culture, health and development (15 ECT)	Some chapters on multiculturalism and an article about values; no explicit mention of religion or spirituality
	Professional training (5 ECT)	Communication training that includes cross-cultural aspects
	Psychological Interventions *(master, not clinical, 14 ECT)*	Existential issues, religion as background for mindfulness-based therapy.
UiO (Oslo)	Psychological prevention: cultural perspectives (10 stp)	Seminars on culturally sensitive psychotherapy, bias, minorities; no explicit mention of religion or spirituality
UiT (Tromsø)	Professional training (5 stp)	One of three course sections uses book chapters such as «consensual reality, spirituality, and religion»
NTNU (Trondheim)	No courses on culturally sensitive psychotherapy, religion, or spirituality	---

Summary

Considering the critical aspects discussed above, the third study in this PhD-project provides a unique possibility to produce knowledge that is directly relevant to decisions regarding the training of future psychologists in Norway. To the best of my knowledge, no other study has addressed this topic, and the 2005/2009 study is the only one that has investigated the question of religion and spirituality as part of clinical psychology training in Norway. Replicating the study 15 years later provides the possibility to make well-founded statements regarding the situation today and also about developments over the last decade.

Mixed methods – mixed epistemologies?

For the quantitative sections of this PhD project, surveys were used and high sample sizes were obtained (262 in the first and 650 in the third study). Both are traditional quantitative studies. Instead of talking or writing freely, participants were required to choose from a number of

multiple-choice responses. The responses were analysed using statistical methods. Variable operationalization, scores, and sum scores as measurements and the search for statistically significant numbers to test hypotheses are classical methods that appear to be consistent with a positivist way of producing knowledge. It can be argued that the “truth” about what survey respondents do and believe can be deduced from their responses.

The qualitative part of the project employed semi-structured interviews with a group of specialists on the specific topic. The purpose was to comprehend motives and attitudes, and thematic analysis was used to do so. One of the possibilities that the researcher may have to consider in this type of research is that, when patients and therapists have a similar religious cultural background, they may tend to support one other's religious or spiritual constructs (Geertz, 1966). The therapist in this scenario is not trained to have an outside point of view, as proposed by Griffith (2010). This approach with its epistemology can be seen as classic qualitative research that belongs to the social-philosophical tradition, based on constructivist theories and hermeneutic methods. The focus is on inductive reasoning and the interpretation of interpretations.

Therefore, on the one hand, it could be claimed that the study's foundation contains two incommensurable epistemologies, resulting in inappropriate combinations of essential lines of argumentation.

On the other hand, if one considers the criticisms that have been levelled against this form of dichotomous description (Mesel, 2013) and examines the research in more depth, it is possible to find a harmonising perspective. Already during the design phase of the survey used in the data collection in the mental health clinics, the authors questioned the concept of "spiritual care" and the underlying terminology (Frick et al., 2019). They acknowledged the multiple levels of meaning that can be found in "spirituality" and "religiousness" (Stifoss-Hanssen, 1999) in the context of health care. Eventually, while translating the questionnaire into Norwegian, it became evident that the word “spirituality” and the respective concepts in the two languages that reflect differing traditions are not interchangeable. "Spiritualitet" in Norwegian has a distinct tone and different connotations to "spirituality" in English and German. “Spirituality” and “Spiritualität” seem to address the inner experience of transcendence more generally, both in- and outside traditional religion, while “spiritualitet” in Norwegian may have an overtone of new religiosity, and Scandinavians may prefer expressions such as “meaning making”, “existential”, or even “religious” to express the same phenomenon (Stifoss-Hanssen, 1999). The questionnaire clearly does not merely measure a given reality, as would be the case in a

positivist approach. Instead, it may be seen as a close approximation of anything that can be regarded as a given reality. Therefore, despite the use of seemingly classical quantitative methods, this part of the study has elements that cannot be associated with a positivistic approach.

Similarly, the qualitative part of the study can hardly be termed purely constructivist. This would be the case if it operated without any shared reality and depended only on participant and researcher interpretations of their own constructs. Instead, this research is based on the premise that there is a reality that consists of individuals (patients) in the health care system who experience actual pain and for whom therapists pursue effective therapy. Whether the elements in this system and their relationship are constructed or real is irrelevant to the research. Rather, also in this study, the philosophical underpinnings of the investigation are largely based on the assumption that there is a reality that the data refer to.

Therefore, both the qualitative and quantitative aspects of the study converge on the philosophical stance of critical realism (Benton & Craib, 2011, pp. 120-141; Lipscomb, 2008), and they inform one another regarding the many epistemological traditions throughout the history of approaches used. The quantitative components in the project can provide information about the "spiritual competence" in health care, particularly among psychologists, regarding possible correlations between personal spirituality and the way existential questions are addressed in therapy, and about spirituality as a component of clinical psychology education, while the qualitative component provides information about the same topic from a different perspective, namely what "spiritual competence" means to a therapist.

In summary, construct validity and the internal coherence of the mixed-methods design are two aspects in the examination of the methodological quality of this thesis. The ambiguity of "spirituality" as a study subject must be considered as a potential limitation in the validity, and the contrasts between spirituality, religion, and existential problems must be examined. However, an open, inclusive notion in the definition of spiritual competence seems helpful since it encompasses as well as exceeds the therapist's own spirituality. Addressing a wide concept in a wide manner may, in fact, lead to less fuzziness than attempting to define concepts such as “spirituality” in an overly constricted manner and thereby risking a lack of connectivity for the diverse definitions of the participants. By asserting a philosophical stance of critical realism that is applicable to both qualitative and quantitative research, thus both constructivist and moderately positivist epistemology, the study can be defended against allegations of incommensurability. Applying a similar line of argument as above, critical realism opens an

epistemological field that provides a less restricted and limiting combination of methodologies than more radical approaches, such as pure social constructivism or traditional positivism. Thus, it may be argued that this mixed-methods study is more solid, not despite of but rather as a result of the complementing origins of the research techniques. The research questions, the relevant constructs and models, and the epistemological stance of the researcher all represent a coherent combination of different types of knowledge.

Mixed-methods validity

Since the middle of the 20th century, discussions on mixed-methods research have become increasingly intense and intricate. "Mixed methods" may signify quite different ideas when distinguishing between quantitative and qualitative components of a parallel or sequential data collection and depending on what the primary emphasis of the study is (Morse, 1991). The number of combinations and labels becomes nearly infinite because both qualitative and quantitative research are presented in great variations, with implications for study design features and possible interpretation. This is mirrored by the debate on the appropriate terminology when mixed method, mixed models, triangulation, or multimodal design are discussed (Hussy et al., 2010). Consequently, the philosophical background(s) of mixed-methods research has been widely discussed and has generated some focused debates, such as the question of whether paradigm and method should fit, or whether different paradigms in different parts of a study could enhance knowledge production. Another question is whether there is one “best” paradigm to fit mixed-methods research. In this field, the pragmatist approach seems to have gained popularity over the methodological purist and situational approaches (Hanson et al., 2005). In the pragmatic approach, the paradigm is defined by the research issue and the researcher, not the methodology. Heeks et al. (2019) argue that pragmatism on its own has some philosophical shortcomings and should, therefore, be combined with critical realism, as has been done in this study.

There are numerous recommendations for a common vocabulary for a more accessible description of mixed-method research, such as the three dimensions of a) the amount of method mixing, b) temporal orientation, and c) the focus of the approaches (Leech & Onwuegbuzie, 2009). Hanson et al. (2005) propose six primary mixed-method designs that may also be used to discuss the quality of research, differentiating between sequential or concurrent, explanatory or exploratory, and transformative designs.

The three studies in my project were not conducted sequentially; instead, they were conducted concurrently. The design does not entail the direct use of the data from one study as a starting point for another, but the intention is that the findings of one study should show features that cannot be the focal point of the others. This research on the existence of existential competence in health care, for instance, does not reveal what psychologists believe regarding the many facets of this competency, and there is no claim that the qualitative interview study provides a representative statistical overview. The primary perspective of the thesis is exploratory, and explanatory aspects are important, but secondary. Neither the qualitative nor quantitative components are obviously prioritized. In addition, the quantitative research focuses on quite distinct facets of the competency, with one examining whether it exists in health care and the other focusing on university training for psychologists in Norway. Therefore, "triangulation" seems to be the most appropriate description. Regarding the epistemological approach, however, “crystallisation” (Ellingson, 2009) is the more appropriate term, as it refers metaphorically to the different colours of a light beam that become visible by sending it through a crystal. In the discussion part of this thesis, both the different aspects and the overlapping results are considered.

It is more difficult to identify whether or not the research has an advocacy perspective (and so fits what Hanson calls a "transformative design") and, if so, how to define it. I conclude that it has, and, for a more detailed discussion and justification of this statement, see the following section on ethical considerations.

Ethical considerations

The latest version of the “Guidelines for Research Ethics in the Social Sciences, Humanities, Law and Theology”, published by the Norwegian National Research Ethics Committees (NESH, 2021), provides an extensive list of considerations for ethically responsible research. Some need formal responses, such as informed consent forms and data safety procedures, while others do not have a straightforward answer but require reflexion and careful balancing of values and options.

In this thesis, the formal necessities were closely monitored in the research and publication processes for the respective articles. Apart from the online survey of the students, which was completely anonymous, every study required formal overview from the Norwegian Centre for Data security, including a study protocol, an evaluation of the interview guideline and the survey questionnaire, participant information, and the data security plan. For the quantitative

studies, there was additional monitoring by the participating research institutions (University of Oslo and Ansgar University College) and data management plans that clarified the rules for distribution and collection of questionnaires for the hospital studies were also required to ensure anonymity and voluntary participation.

Beyond the formal framework of social science research, however, this thesis was challenging in several ways and required further reflexion.

Spiritual self-disclosure in spiritual self-disclosure research?

In a study on the different approaches of researchers to spiritual content in therapy protocols, West (2009) discusses the challenging position of the researcher in research on spirituality and concludes that this type of qualitative research should "at best can aim for 'critical subjectivity' (…) rather than some pretence to objectivity", because, similar to gender, race, or class, the "soul filters knowledge" as well. Therefore, ethically sound research must be reflective, as Lazard and McAvoy (2020) also note.

Obvious challenges and dilemmas in my study are the perception of personal bias on the part of the participants and myself; a positive attitude towards religion and spirituality could cause blind spots in critical thinking regarding the integration of spirituality and therapy and an exaggeration of its benefits. This becomes even more complex, as an important aspect of my study is the question of spiritual self-disclosure of the therapists to their patients, which is reflected in a parallel question in the research interview: Is spiritual self-disclosure of the researcher a risk to research quality or could it be beneficial or even necessary? In an article about psychoanalytic interviews, Kvale (1999) emphasises the interrelational and conversational production of knowledge in both therapy and in qualitative research—when the interviewees discuss spirituality, their perception of the researcher's spiritual background will influence the relationship, their choice of words, and, thus, the knowledge produced. It is impossible to display spiritual neutrality. The choice of research topic and the institutional background of the researcher (Ansgar University College is part of "Misjonskirke Norge") are strong indicators that could influence participants in several ways. Those who share the general spirituality of misjonskirken could feel encouraged to stress matching experiences and thoughts and neglect critical aspects. Participants with different spiritual backgrounds might hold back on topics that they expect could cause conflict or be less open about spiritual experiences they may perceive to be less acceptable in evangelical contexts. Thus, neglecting self-disclosure and opening the relationship to the participants' subjective interpretation of external indicators of

spirituality would be a potential risk to research quality. If the researcher overemphasises self-disclosure, it may have a similar effect. Similar to the results of the self-disclosure debate in therapy (Bloomgarden & Mennuti, 2009; Zur, 2007), the right amount of self-disclosure may be a solution for the research process; provide enough information to be open to an authentic encounter and to emphasise the non-judgemental position of the researcher. I attempted to solve this challenge in my project by briefly presenting myself as a fellow therapist with a generally positive but conflicted spiritual biography who wants to find new insights into the intersection of professional psychotherapy and the spiritual domain through research. The same amount of openness seems appropriate in presenting and discussing the findings.

Advocacy

My dissertation contributes to the scientific discourse within the psychology of religion and spirituality. This branch of academic psychology is highly interdisciplinary, has a rich history, and has had respected representatives in the psychological scientific community from the outset, with researchers such as S. Freud and W. James. This bears witness to a tradition of scientific disinterest and neutrality. At the same time, the psychology of religion and spirituality is mainly rooted in US-American Christian culture and is largely supported by Christian institutions. This thesis is based in a Christian-owned university college, and the subject has the support of the institution. Therefore, it is not neutral in terms of institutional context. Personal inspiration for the research has been derived from a combination of clinical experience and spiritual growth. Many experts contend that there is no such thing as neutrality in complicated subjects such as spirituality (Audet, 2011). It is therefore difficult to categorise this thesis in terms of scientific neutrality or advocacy. Standpoint theory (Harding, 2009) asserts that it "includes the excluded" and focuses on the distinction between oppressed and oppressive scientific methods. On the one hand, Christianity, with its colonial, white, and, often, violent past, is likely to bring forth oppressive research when attempting to promote spirituality in psychotherapy, according to the feminist tradition. This would be an argument against the credibility of this study. On the other hand, the function of spirituality in the tradition of psychology and psychotherapy in the secular setting of Norway may be regarded as suppressed or, at least, disregarded (Danbolt et al., 2014; Engedal, 2011). Thus, it may appear to be an effort to include something that has been omitted. It is, however, necessary to consider the advocacy tendencies of both the employing organisation and the researcher to ensure the scientific validity of the study.

Elements of power

The elements of power in the topic of this thesis are complex. On the one hand, psychotherapy patients are in many ways dependant on their therapists and therapy is done behind closed doors; on the other hand, psychotherapy is meant to be an institution of emancipation and a place of safety for the powerless. Therefore, power is a general issue in psychotherapy.

Moreover, the topic of spirituality, especially religion, has many different aspects of power: Traditionally, Christian religion is associated with (male, white) oppression of, for example, women, and institutions such as churches that have hierarchical structures—while one core impulse of Christianity is loving solidarity with the poor and disenfranchised. Religion can be therapeutically misused (see the debate on homosexuality in therapy), but it can also seem as if religiosity and religious people need protection from therapeutic negligence, and religiosity is often an important topic for minorities. As a white male researcher from a Christian institution, I could be identified with all of these aspects.

The participants in the interview study are psychologists (in the other studies, students of psychology and health professionals) from privileged backgrounds with a sound legal framework. Nevertheless, citing psychotherapists who talk about themselves and their work must be done with respect and care to avoid using them as instruments for what I think is right and necessary in the field of psychotherapy. I had to avoid selective citation and actively search the interview material for positions that contradict my own assumptions. Open questions and allowance for free comments form part of this. Returning the results to the participants could have alleviated this challenge, but the time frame of the project did not allow for this.

The assumption of the existential and spiritual needs of psychotherapy patients is part of my study's framework. Thus, by conducting the study, I may not be *speaking for* the patients as a vulnerable group, but I am *investigating on their behalf*. This can be beneficial, as psychotherapy patients tend to have little input into the organisation of therapy or the training of therapists; they are treated, diagnosed, and are on the downward side of the power balance between therapist and patient, unless the therapist remains aware of serving the patient to work through a mental challenge. The therapist, on the other side of the power balance, is well protected by legal secrecy and professional distance. In addition, my position is problematic, as the assumption of neglected spiritual and existential needs is based on literature and personal experience—the patients do not have an active role in my studies. I have to rely on the validity of other studies, as the timeframe of a PhD does not allow own investigation among patients.

Some of the participants reported that they had experienced prejudice and obstacles at the workplace because of their interest in spiritual questions in psychotherapy. Therefore, in some way, I am speaking for them as a minority among secular psychotherapists. Presenting their experiences as well as their high professional sensitivity in a balanced way may be beneficial, as it could foster the view that spirituality and professionality must not be opposites in therapy. Being aware of the ethical pitfalls in this context would be a precondition to avoid the impression of bias in my argumentation.

As a conclusive definition of this thesis, with consideration of these methodological, epistemological, and ethical reflexions, the research has a stance of critical realism and a concurrent transformative crystallisation design, according to the categories of Hanson and Creswell and the terminological modification of Ellsworth.

Summaries and results

In this chapter, I briefly summarise the three studies included in this dissertation, present the relevant results, and illustrate the interconnection of the results in this mixed-methods design study.

Paper one—Norwegian psychotherapy: religiosity gap and spiritual care competence

Summary

One way to address the main research question about the role of religion and spirituality in Norwegian psychotherapy is to explore the status quo. Relevant studies for the Norwegian context are lacking. The attitude and practice of psychologists in mental health care compared to other professions, as well as possible correlations with factors such as age, gender, or personal religiosity are especially interesting. Research highlights a number of possibly relevant connections between (a) personal, (b) professional, and (c) societal variables and the openness towards and skill to include religious and spiritual questions in mental health care:

a) Age and gender seem to be consistent predictors for personal religiosity (Brown et al., 2013). Obviously, on the one hand, a positive attitude towards religion and spirituality could foster the idea that this dimension is also important to patients. Professionals, on the other hand, seem to overestimate their own skills in this area, especially when they are themselves religious (Oxhandler et al., 2017).
b) Bergin and Jensen (1990) described the "religiosity gap", an imbalance in attitude between psychotherapists and their patients, with possibly negative treatment effects. Since the initial study, many others have replicated it (Stephan & Utsch, 2017) or come to different results (Hofmann & Walach, 2011). There seems to be no doubt, however, that the training of psychotherapists, in Norway as well as internationally, lacks focus on the religious/spiritual domain (Jafari, 2016; Reme et al., 2009).
c) In secular Western societies such as Norway, health care seems to maintain a distance from religious traditions, stressing their foundation in evidence-based diagnosis and treatment (Hvidt & Hvidt, 2019). However, spiritually inspired therapy approaches such as mindfulness-based stress reduction or acceptance and commitment therapy are part of many clinical programmes (Heidenreich & Michalak, 2013). These contrasting processes are likely to impact mental health professionals in their daily work. In addition, secularisation seems to be a generational phenomenon (Taule, 2014) .

To explore these variables and their interconnections, the Spiritual Care Competence Questionnaire (SCCQ) (Frick et al., 2019) was distributed to professionals in three mental health care institutions in Southern Norway. Two-hundred and sixty-two staff members participated, of whom 92 were psychologists (36%).

Results

The results related to the variables mentioned above indicated the following:

a) Regardless of profession, spiritual care competency scores varied but were in the lower range for all respondents (Figure 6), while older participants scored somewhat higher. Personal religiosity, measured by "actively believing", "church membership", or "prayer/meditation", was shown to be significantly stronger in the older generation (Figure 7). However, there was no significant difference for gender.

Figure 6

Means of spiritual care competence factors in the sample

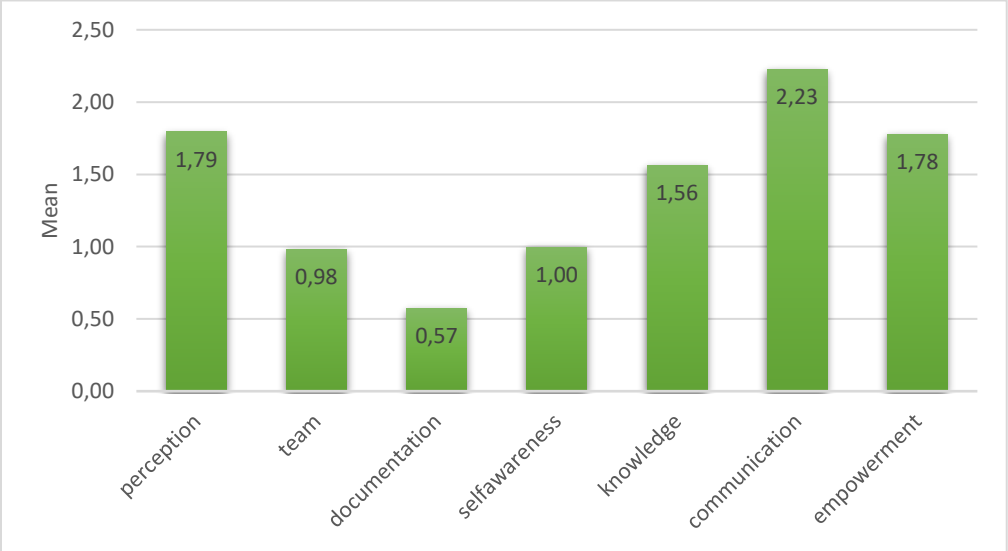
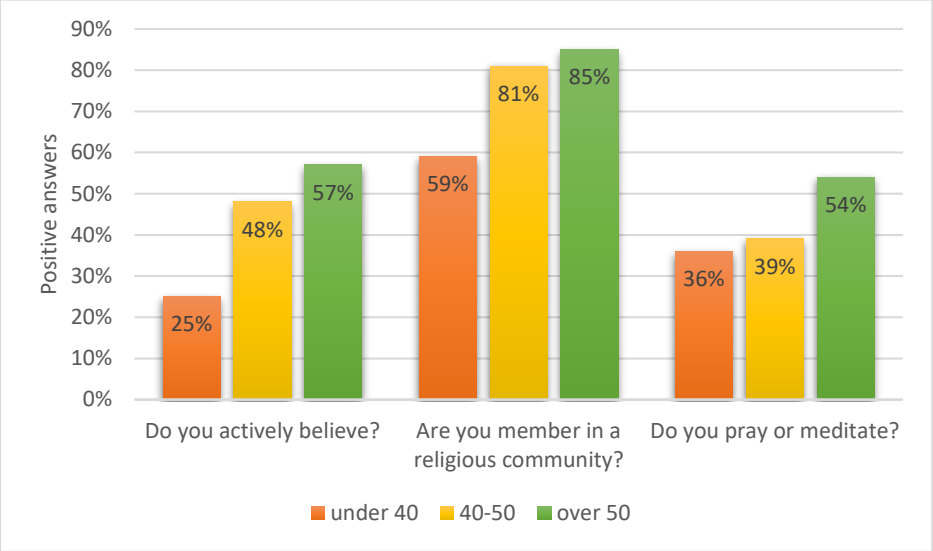


Figure 7

Positive answers to the question of believing, membership, and prayer/meditation, comparing age groups (n = 262)



b) Psychologists were significantly less religious than other health professionals who work in mental health care. The religiosity gap was the most noticeable when psychologists answered the question "Do you actively believe?", which only 31% of the psychologists answered positively, in contrast to 50% of the other professionals. The difference was less with the question about church membership and not significant for the question of meditation/prayer (figure 8).

Figure 8

Percentage of positive answers to the question of believing, membership, and prayer/meditation, comparing profession groups

c) The results indicate an open attitude towards religious and spiritual topics in principle among psychologists, but some hesitation regarding addressing them practically. When asked directly if they can talk to their patients openly about religious/spiritual needs, 65% of the psychologists answered positively. However, when asked whether they address religion/spirituality when talking with patients, only 12% said yes. On the one hand, 20% of the participating psychologists agreed to the claim that religious topics were not included in their job. On the other hand, 61% claimed that they integrate patients' religious/spiritual needs into therapy. The self-reported competence of the documentation of religious information, however, is as low among psychologists as in other professional groups, similar to the competence of team communication regarding this dimension or knowledge of religion(s). Overall, the attitudes and skills in this area can be regarded as inconsistent.

Paper two—Stepping carefully on sacred ground: religion and spirituality in psychotherapy

Summary

A second important perspective when attempting to answer the main research question of the role of religion and spirituality in Norwegian psychotherapy is to develop an idea of the potential therapeutic gain and the challenges related to an integrative approach. To achieve this

goal, I chose a qualitative approach that targeted experts in the field. I invited licenced Norwegian psychologists who had published articles about the intersection of religion/spirituality and psychotherapy and/or had participated in a public debate on the topic to participate in the study. In addition to professional qualifications and the combination of relevant practise and reflection on the topic, I aimed at a divergent sample with different spiritual/religious backgrounds and different specialities, ages, and genders. Eight psychologists accepted the invitation, four men and four women aged between 30 and 65, who work in different institutions and in private practice. Their spiritual/religious backgrounds ranged from continuous free church socialisation to agnostic, with varying shades of spirituality. In semi-structured interviews, I asked the participants about their understanding of religion, spirituality, and existential issues in psychotherapy and encouraged them to share their experiences, regarding both their patients and themselves. One hundred and fifty-one pages of transcription were analysed, following a directed content analysis strategy (Assarroudi et al., 2018) and combining a deductive grouping of parts of the interviews and an inductive analysis of the text.

Results

The interviewed psychologists shared a common understanding of the importance of religious and spiritual topics in in therapy—which is not surprising since one of the selection criteria was an active interest in the field. In addition, they also shared a common terminology regarding to the terms “spirituality”, “religion” and “existential questions”, terms that have been the subject of academic discussion for a long time (Zinnbauer et al., 1997). The therapists agreed on a rough definition of spirituality as the individual search for a connection to higher meaning and the supernatural, while religion implies the institutionalised, traditional, and often ritual form of this search, performed in fellowship. Existential questions were described as the deep common questions of life, meaning, purpose, and connection, shared by all humans. Most importantly, however, the therapists emphasised that it is not the academic definition but the clients’ individual understanding that counts and should be the focus of therapeutic attention.

The psychologists in the study went much further in their statements than simply stating the importance of religious/spiritual questions in therapy, as could be expected because of the selection criteria. They underpinned this claim by providing numerous examples from their own practice for religiosity or spirituality as sources of psychological suffering that needed therapeutic attention or as resources that could be used for progress in therapy in times of crisis and in the area of personal growth. To balance the positive and negative aspects of religion and

spirituality in therapy, the psychologists emphasised the importance of self-reflection and therapeutic integration of these matters. They stated that a simple pro-religious or pro-spiritual attitude could be just as harmful as a consistently critical approach. In this context, many of the therapists described the challenge of adequate religious/spiritual self-disclosure in therapy. While some clients may profit from a feeling of religious/spiritual solidarity, others may need a respectful but more confronting dialogue. To position oneself adequately as a therapist in the context of ethical standards that require a professional distance was experienced as challenging—a topic that the therapists considered was widely neglected during their university training.

A third area of results is related to the importance of religion and spirituality for work motivation and the self-understanding of the therapists. In various ways, depending on their religious and spiritual backgrounds, the therapists reported a variety of advantages that they have experienced in their work: a firm set of values; religious knowledge or a sense of vocation as well as a surplus of hope, also for challenging patients; the experience of not being alone in difficult therapy situations; or a strengthening of the therapeutic relationship. They also described "sacred moments" in therapy, instances of special presence and deep meaningfulness that they attributed to the religious/spiritual dimension.

Paper three—Religious sensitivity at secular universities: a cross-sectional replication study among Norwegian psychology students

Summary

A third way to explore the role of religion and spirituality in Norwegian psychotherapy is to examine the extent of the attention the topic receives in the training of future psychotherapists. The only study that has investigated this before is 15 years old (Reme et al., 2009). The results show a negligence of the topic at Norwegian universities, despite a broad interest from the students. In recent decades, international academic attention in this field has increased considerably, and religious sensitivity has been linked to cultural competence, an issue of growing importance in times of migration and multicultural societies. Openness to diverse cultures has become a regularly promoted core value in psychology. At the same time, practitioners, teachers, and researchers seem to practise this openness only reluctantly, especially related to religious diversity (Plante, 2014). However, there was no evaluation of the current situation in Norway. Therefore, I decided to replicate the 2005 study, using the same survey and inviting all students of clinical psychology at the four universities that offer the

subject. The survey (see above for methodology) was distributed via *Nettskjema*, a digital platform, in 2020.

Results

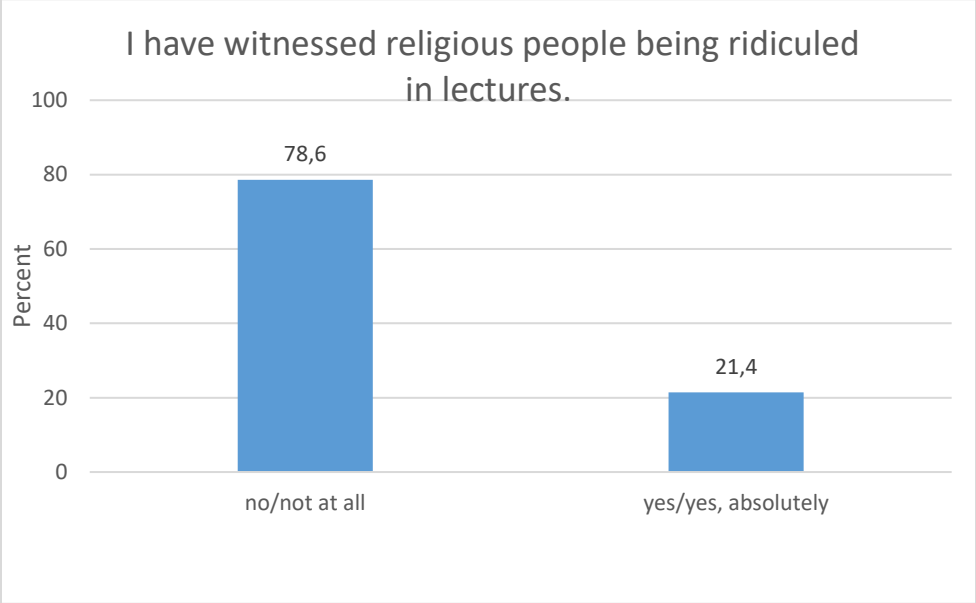
Six hundred and fifty students responded to the survey, with slightly varying response rates from the four universities. Compared to the results from 2005, there have been no significant changes, either in the inclusion of religion and spirituality in teaching or in sensitivity related to the topic. Eighty-nine percent of 2020 students reported that religion was not part of their training (Figure 9), and 21% said that they had experienced religious people being ridiculed during lectures (Figure 10). A more detailed evaluation of the inclusion, however, showed an increase in some aspects of the teaching, for example, comments, examples, or recommended articles.

Figure 9

Student-reported Inclusion of Religion in the Clinical Psychology Training Programme at Norwegian Universities, 2020 Sample (n = 650)

Figure 10

Experience of Disrespectful Communication, 2020 Student Samples (n = 650)



When the survey findings were compared to national norm data, they seemed to correlate with psychological and sociological research on secularisation internationally and with special focus on Scandinavia (Hvidt & Hvidt, 2019; Repstad, 2020a). Today's students, similar to the population in general, are more diverse and individualistic, also in regard to religion. Even though the overall religiosity in the 2020 sample is slightly lower compared to 2005, the number of religious and extremely religious students is significantly higher. It can be concluded, therefore, that religion and spirituality has not become a topic of lesser importance, but, on the contrary, that it has become a topic of stronger divergence and potential disagreement and that university teaching has not kept pace with this development.

Discussion

Overarching findings and interconnection of results

The mixed-methods results in this thesis can be approached in at least two different ways. First synchronic, by interpreting the different aspects as different supplementary crystallisations of one picture and highlighting overlaps or contrasts. Second, diachronic, by focusing on the developmental aspects of the data, with the consideration that the participants belong to at least two generations of psychologists: those who have been previously trained and are practitioners now and those who are currently in training to be practitioners in the future. Moreover, the experts in the qualitative study could be regarded as representatives of a future generation of psychologists in the sense that they already show a competence in managing spirituality and religiosity in a way that would be desirable for future psychologists.

Synchronic interpretation

The research subject was approached from a variety of perspectives by the three studies that contribute to this thesis. However, at least two, if not all three studies, support the same conclusions in a number of ways. The overall image of the results can be enriched by combining these findings. I want to focus on three aspects: religion/spirituality as exceptions in psychotherapy, insecurity regarding religious/spiritual self-disclosure, and the high level of personal and professional interest.

Focus on religion and spirituality as exception

The majority of psychologists in the clinical study would not pursue religious or spiritual topics in therapy actively, and 20% even stated that this dimension is not part of their job. The experts in the qualitative study described themselves unanimously as exceptions in their circle of colleagues; some talked about being asked for advice for religious questions concerning patients, while others reported repression and prejudice. Psychology students, today and 15 years ago, say that religion and spirituality are not covered in teaching. These claims are confirmed by university staff and accessible official curricula. This means that the main research question ***"Which role do religion and spirituality have in Norwegian psychotherapy?"*** can be answered by saying ***"a marginal one"***. These findings align with results from similar studies in other countries (Freund & Gross, 2016; Jafari, 2016).

Insecurity about the therapist's role

The answers of psychotherapists in the clinical survey show a peculiar inconsistency; on the one hand, there seems to be an acknowledgement of the religious/spiritual dimension and an openness to talk about it (59% of the participating psychologists say that they foster religious and spiritual reflexion, 61% say that they integrate patients' religion and spirituality in therapy). On the other hand, there is hardly any communication about it in the team (15% say that there is team reflexion on patients' religious and spiritual needs, and only 7% that there is dialogue about team members' personal needs) and little acknowledgement of the impact that the psychologists' personal attitude may have on religion and spirituality in therapy (only 34% answered positively). This inconsistency can be interpreted as an insecurity in the attitude towards the therapist's role and corresponds with the reports of the psychologists who actively integrate religion and spirituality in their work; the question of religious and spiritual self-disclosure remains a challenge and they were cautious about not taking too much space while, simultaneously, wanting to "open a room" for religion and spirituality. Some wondered whether the authorities' regulations match their therapeutic reality. None felt well-equipped for the task by their university training—a claim that corresponds with the findings of the replication study. In the light of these observations, the main research question ***"Which role do religion and spirituality have in Norwegian psychotherapy?"*** can be answered by saying ***"an ambivalent one"***. These findings align with qualitative research on the therapists' experience and self-understanding, which highlights a high degree of spiritual involvement as well as many conflicted religious biographies among psychologists (Blair, 2015; Magaldi-Dopman et al., 2011).

High level of personal and professional interest

There is a third way of interpreting the findings of the three studies synchronically. Since it was one of the selection criteria in the qualitative study, it is to be expected that the participants in this study were interested in the intersection between religion and spirituality and psychotherapy and attached high significance to this dimension. However, the intensity of their personal involvement, as discussed above, was remarkable. Both quantitative studies, however, involved psychologists/students in general and some measures were taken to avoid a selection bias in favour of those interested in the topic—the critical comments in the free text passages as well as the ambivalent results discussed above seem suggest that there is at least no overwhelming bias in the data. Nevertheless, the results of both quantitative studies can be interpreted as signs of general interest in the topic. The most explicit interest was in the student

study; 50% of the students considered "a spiritual dimension […] an important part of psychology", and 60% think that there is too little focus on this dimension in psychology training. Moreover, the participating practitioners can also be understood in this way. Notwithstanding their ambivalence, as discussed above, 80% of the psychologists did not agree with the claim that religious and spiritual topics were not part of their job, and 57% claimed that they "see their patients' spiritual needs". Despite the religiosity gap discussed above, 31% of the psychologists said that they actively believe, and 67% are part of a religious community. These numbers are somewhat smaller among the students: 22% said that they are religious, and 40% are members of a religious community. Thus, from this perspective, the main research question ***"Which role do religion and spirituality have in Norwegian psychotherapy?"*** can be answered by saying ***"a relevant one"***. These findings correspond with relevant studies that originated from different cultures (Hofmann & Walach, 2011; Pargament et al., 2014).

Summarizing the synchronic interpretation, if religion and spirituality in Norwegian psychotherapy can be regarded as marginal, ambivalent, and relevant, it can be regarded as neglected. The contrast between high professional and personal interest, low inclusion in training, and insufficiently defined practice suggests that the religious and spiritual dimensions deserve more attention.

Diachronic interpretation

Interpreting the results as not only crystallisations of one static picture but also as different facets of a dynamic development enables an analysis of the status quo as well as speculation about the "motus quo", and opens up the floor for some qualified guesses on the most relevant implications. Before embarking on that discussion, I will first focus on three possible developmental aspects: the correlation between the lack of teaching and lack of practice, the feedback related to insecurity, and the increasing demand for cultural competence as an opportunity for change.

Lack in teaching corresponds with lack in practice

Although the practitioners in the quantitative health care study and in the qualitative study are from different generations, they have in common that they have all received Norwegian clinical psychology training in the past—the oldest participant completed their studies during the 1980s, and the youngest in the late 2010s. The 2005 student study and the 2020 replication demonstrate that there has only been minimal changes in the psychological teaching on religion and spirituality, and it can be assumed that the situation was similar during the years between the

1980s and 2005. Notwithstanding numerous social variables, today's practitioners can not only be regarded as products of their training, but also as models for future psychologists who have to undergo the same type of training that they had. Since little change was noted in the psychological curricula concerning religion and spirituality, it may be safe to argue that today's psychology students are not likely to become more competent practitioners than the participants in the presented studies in regard to religion and spirituality. The experts in the qualitative study reported that they had gained their spiritual care competence through personal interest and private study. They did not feel well-prepared by their university training and regarded themselves as exceptions among their colleagues. The majority of psychological clinicians in the quantitative study demonstrated insecurity and a lack of initiative. Without further changes in university training, this is likely to continue into the future, when the current students enter clinical practice. The experts, however, mentioned potential ways of teaching; they named self-reflexion, existential psychology, value-oriented therapy, and Eastern philosophy as possible helpful lessons for future psychologists. Thus, from this perspective, the main research question ***"Which role do religion and spirituality have in Norwegian psychotherapy?"*** can be answered by saying ***"one of unrealised potential"***. Studies from other parts of the world have had similar results (Pargament, Mahoney, Shafranske, et al., 2013).

Feedback of insecurity

The results of both the qualitative and the quantitative clinical study seem to correspond with research that shows what psychotherapy patients expect or do not expect from their therapists regarding religion. Religious patients tend to prefer spiritual counsellors, because they assume that psychologists may not accept their faith (Stephan & Utsch, 2017). Patients in family therapy report an under-communication of spirituality (Holmberg et al., 2017). In my studies, 20% of the clinical psychologists claim that religious questions are not part of their job, and, despite an openness towards spirituality, only 12% ask their patients directly. Participants in the qualitative study reported that patients tend to hold spiritual information back in group therapy to avoid endangering a personal resource. Therefore, patients and therapists seem to reinforce the feelings of insecurity on both sides. Thus, positive examples of spiritually integrated psychology can hardly find their way into university teaching, so the feedback of insecurity that affects the relationship between therapists and patients in the therapy room will also exist between today's and tomorrow's psychological and therapeutic culture. This culture is formed at universities that do not provide their open and interested students with teachers and role models who are secure with religious, spiritual, and other existential issues. Thus, from this

perspective, the main research question ***"Which role do religion and spirituality have in Norwegian psychotherapy?"*** can be answered by saying ***"one of unfortunate reciprocal inhibition"***. This finding is supported by several studies from other contexts (McVittie & Tiliopoulos, 2007; Stephan & Utsch, 2017).

Cultural competence as a chance

The diachronic perspective does not provide a picture of an exclusively static or even restrained development. There is also change. Students who participated in the 2020 study reported significantly higher rates of religion and spirituality as topics in examples, discussions on campus, and research articles compared to the students in the 2005 study—this corresponds to universities' efforts to include cultural sensitivity in teaching, in accordance to Norwegian education law (Kunnskapsdepartementet, 2020). Therapists who participated in the qualitative study talked about the importance of their spiritual competence in relation to therapy with migrants and patients with diverse cultural backgrounds. The invitation to do research at Sørlandet Sykehus was promoted by the leaders because of the hospital's aim to become more inclusive. Religious sensitivity, especially with migration and secularization as growing social factors in Norway (Furseth et al., 2019), is communicated as part of a general cultural competence. This categorisation seems to lend religion and spirituality a more positive connotation than the former suspicions of missionary intentions (Petzold et al., 2009). It is therefore no coincidence that, while the 2005 student survey was published under the title of "Negligence of Religion in Psychology Training" (Reme et al., 2009), the replication found its way to publication with "Religious Sensitivity at Secular Universities" in the title. Clinical psychology may still be critical towards traditional religiosity, but it is open to spirituality as part of modern therapies such as acceptance and commitment therapy or dialectical behaviour therapy and as part of a more general cultural sensitivity. Thus, from this perspective, the main research question ***"What role do religion and spirituality have in Norwegian psychotherapy?"*** can be answered by saying ***"an increasingly important one"***. Findings from studies from other countries support these findings (Guest et al., 2017; Turpin & Coleman, 2010).

Summarizing the diachronic interpretation in extension of the synchronic, the following can be stated. If religion and spirituality in Norwegian psychotherapy can be regarded as having unrealised potential, effectuating unfortunate reciprocal inhibition, and becoming ever more important as part of culturally sensitive psychotherapy, it can be regarded as a neglected but growing topic. It does not only deserve more attention, but it is also starting to attract attention, and there is reason to expect positive impacts on the quality of psychotherapy in Norway.

Limitations

Regional limitations

Focussing a study on a small country such as Norway is both a strength and a limitation. On the one hand, the data, especially with the use of a mixed-methods design, can provide detailed analyses of the situation in one of the Scandinavian societies. On the other hand, compared to an international perspective, this approach is limited, and the study could almost be described as a case study with key-hole perspective. Moreover, both studies involving practitioners are limited to only the southern parts of the country; the three participating institutions are situated in Kristiansand, Vikersund, and Oslo. Even though these regions have the highest population density, they are not representative of Norway's western and northern regions, with their special culture and religious traditions. This is also true for the participants in the qualitative study, although their regional backgrounds were somewhat more varied.

However, the student study included all the relevant Norwegian universities, namely Tromsø and Trondheim in the north and Bergen in the west. Throughout the research process, we attempted to balance the regional limitations by constantly discussing international literature and working together in international teams. Both the qualitative and the quantitative clinical study were done in collaboration with German and Norwegian researchers.

Religious/spiritual range

Religious and spiritual diversity is one of the main topics of this thesis. However, there are several limitations to studying this diversity in Norwegian psychotherapy that also affect this study. First, the Norwegian religious landscape differs considerably from that of other countries, for example, the United States, where the bulk of the research in psychology of religion originates from, or Germany, which is an important point of reference for this study. According to the global report on religious diversity (Pew Research Center, 2014), Norway is less religiously diverse than the United States and considerably less than Germany. This ranking is even more relevant taking into account the report's methodology; it considers religions (for example Christianity) as a whole and neglects important diversity factors such as confession (such as catholic or protestant in Germany) or religious commitment in contrast to mere membership, which is considerably higher in the US than in Norway (Pew Research Center, 2018). Following these data, Norway is not the place to study religious diversity. Second, diversity is a challenge in the clinical psychology workforce abroad (Turpin & Coleman, 2010) and, according to media reports, also among practitioners and psychology students in Norway.

Finally, as the above-mentioned circumstances already complicates the study of diversity in Norwegian psychotherapy in the two quantitative studies in this thesis, the data is even more challenging for the qualitative study; attempts to recruit psychologists with explicitly non-Christian religious backgrounds were unsuccessful. The eight participants varied considerably within the Christian sphere (from agnostic, but referring to Christian narratives, to committed Pentecostal), but there were no active Muslim, Buddhist, or otherwise religiously affiliated participants in the sample. Atheists were excluded by the sampling criteria.

The regional limitation of the participating institutions mentioned above is also a limitation of the study's religious/spiritual range. The southern parts of Norway, in the area of Kristiansand, are described as regions with a rather pietistic Christian heritage (Løvland et al., 2008), while the Oslo region is regarded as the centre of Norway's secular society (Schmidt, 2010). The religious traditions of the west or the Sami influence in the north, however, do not have a place in the data. The possible selection bias due to the choice of Southern/Eastern mental health institutions is partly balanced by the fact that the institution in the (more religious) south is a secular one while the two institutions in the (less religious) east have Christian roots. However, it is not possible to estimate the extent to which the data are biased, or whether a possible bias has been balanced.

All in all, the religious and spiritual range of this study must be regarded as limited, although the lager part of this limitation reflects the Norwegian society quite accurately. The student sample as well as the clinical sample were compared to population-norm data and showed a similar distribution of diversity. This also holds true for the qualitative sample. The largest non-Christian religious group in Norway is the Muslim group, with less than a 4% share of the population (Statistisk Sentralbyrå, 2017). Considering the small group of eight participants in the qualitative sample, it might therefore be appropriate to not include Muslims. Nevertheless, it would be interesting to integrate more data in future studies, which could be analysed with regard to real-life diversity and to compare the experiences of psychologists with more diverse religious and cultural backgrounds.

Personal bias

Personal bias in research is probably the most difficult bias to detect and to counterbalance in the research process, as only some of it is conscious. I am likely to prefer information that is critical towards secular psychology and favour information that is related to Christian values and positive about the integration of spirituality, religion, and psychotherapy. When asked

about my project, it is tempting to answer that "I want to show that…" instead of "I want to explore if…", mentally setting an expected result as an end point of my research process instead of asking open questions. Even if I did manage to choose more adequate formulations or could argue that working with hypotheses is an acceptable scientific strategy, the choice of my research question, the sampling strategy, my academic situation at a Christian college with colleagues who would be interested in obtaining similar results, and the choice of co-authors can already be regarded as an expression of a personal bias. There is no such thing as "neutral" psychology, whether in treatment or in research (Leenderts, 2020). One countermeasure is the academic framework, such as publishing in international peer-reviewed journals with high standards of academic credibility. However, there are also strong arguments against the neutrality of these academic institutions (Henrich et al., 2010). The most important measure, therefore, is open communication of my personal and professional background and my motivation for this research project. By providing this information in the introduction of this thesis, I prepare for the possibility that my research will have an appropriate place in the diverse choir of academic voices.

"Missing data"

Finally, in a chapter about study limitations, all the data that were not considered in this study, even though it would have been relevant, should be mentioned. The lack of the integration of university teachers in the educational study has already been discussed as well as the lacking voices of atheist psychotherapists in the qualitative study and practitioners in private practice in the spiritual care study. However, the voices of patients and patient organisations that are only indirectly represented in this research are even more important. Speaking on behalf of a vulnerable group of people without collecting data from them directly is a critical limitation. It can be explained by the time limitations of a PhD project or the ethical obstacles in data collection. It may also be important to note that the thesis is based on a large number of international studies that used patient data and conclude with patients' interest in, amongst others, religion and spirituality in mental health care. A better strategy to address this argument, however, may be to suggest future research that compares data directly from health care professionals and their patients. This would enable the possibility to consider the best ways of communicating religion and spirituality in psychotherapy, the importance of a worldview match between patient and therapist, the therapists' personal qualifications and adequate forms of self-disclosure.

Implications and future research

Existential sensitivity as core competence

Psychological competence for religious and spiritual issues has been defined in different ways. I would like to conclude with a discussion of what it means in a Norwegian context.

With reference to mainly American research, Pargament (2011) has established a tradition that relates to the central idea of the "sacred" and asks for a combination of skills, knowledge, and attitudes as requirements for a relevant competence (Oxhandler & Pargament, 2018). Another US-based research group suggests a relational model in the intersection of spirituality, religion, and existentiality and fosters therapists' sensitivity regarding their clients' spiritual preferences and possible spiritual struggles (Sandage et al., 2020). Drawing on the research tradition of palliative care in Europe (Selman et al., 2014), Frick et al. (2019) conceptualise spiritual care competence as a combination of seven factors: (1) perceptual competence, (2) team-spirit, (3) documentation competence, (4) self-awareness and proactive opening, (5) knowledge about other religions, (6) competence in conversation technique, and (7) proactive empowerment-competence. However, it is an ongoing discussion to establish which of these are the most relevant. Referring to social work as well as health care in the UK and Norway, Dinham (2018) asks for the professional development of "religious literacy". This concept includes knowledge and skills, but also elements of theoretical categorization (what do we mean by and how do we think about religion?) and reflected disposition, comparable to the "attitudes" in Pargament's concept. In a Norwegian context and based on existential psychology, Binder (2021) suggests phenomenological and relational approaches to psychotherapy to allow for existential issues. In addition to the classical four existential questions introduced by Yalom (1980)—death, freedom, isolation, and meaninglessness—Binder suggests the physical and ecological existence as an important field to consider in therapy.

In Norway, with its special combination of strong Lutheran tradition and high degree of secularization, the different approaches mentioned above, although quite close in content, may trigger different associations that should be considered carefully. On the one hand, both "the sacred" as central concept and "religion" as focus in the concept of religious literacy may tend to be misunderstood as siding with traditional religiosity and may lead to resistance in secular therapists and secular universities. "Spiritual care competence", on the other hand, may be perceived as being close to palliative care and chaplaincy and could, therefore, be misunderstood as less relevant for psychotherapy. Moreover, the concept could be criticised for

its complexity with seven factors of unknown distribution of relevance. “Existential sensitivity”, however, seems to be an eminently suitable term, as it can be easily linked to both religiosity and spirituality without being exclusive. This link, however, would have to be done explicitly to avoid an exclusively secular interpretation of the term “existential”. In addition, existential psychology matches the growing attention to “cultural sensitivity”, which includes sensitivity to culturally influenced meaning making, religious or other, and concepts of belonging, freedom, and physical being (Eckersley, 2007). Finally, existential psychology is an established field within psychotherapy, which has influenced numerous modern therapy forms such as mindfulness-based approaches or acceptance and commitment therapy. It may, therefore, be easier to argue for more attention to existential sensitivity in psychotherapy training and practice than it would be to argue for more room for religion and spirituality, although the desired effects would be the same.

Self-reflection as necessary base for appropriate existential self-disclosure

The question of therapist self-disclosure is at the core of therapeutic self-understanding that can vary between the different psychological traditions, as mentioned in the introduction, regarding the relationship between psychotherapy and religion. Psychoanalytic traditions may have a tendency to stress therapist neutrality, and behavioural traditions may tend to focus on manual-guided therapy. Either tendency could, therefore, lead to exaggerated caution in self-disclosure, which can be regarded as a risk for unprofessional therapist behaviour. Therapist self-disclosure in the religious or spiritual domain may seem even more risky in a secular context such as Norway, where religiosity and spirituality is regarded as something that belongs to the private domain (Repstad, 2020a) rather than being related to health. Nevertheless, as shown in the introduction and mirrored in the data, modern psychotherapy varies considerably in the understanding of both the role of the therapist and the role of religion and spirituality in therapy. Among those in favour of self-disclosure, some argue that therapists should “disclose any elements of [their] own worldview, religious convictions, or moral values that might facilitate or seriously impede developing a positive therapeutic connection” (Barnett & Johnson, 2011, p. 160). Others note that “disclosure can pose a risk to the tenuous role differentiation that separates [the client] from their therapist” (Audet, 2011) and ask for the exercising of sensitivity when sharing personal information of any kind. In the introduction to their book about self-disclosure experiences by therapists, Bloomgarden and Mennuti (2009) identify the obedience to Freud about therapist neutrality as a rigid misinterpretation and argue for a judicious measure of self-disclosure. Several reports in the book explicitly touch on the importance of a shared

spiritual dimension in the therapist-patient relationship, to encourage patients' religious identification (p. 61-62) and reflection (p. 176). Zur (2009) reviewed a range of conscious and unconscious forms of self-disclosure and promotes a careful differentiation between helpful boundary crossing and harmful boundary violation in therapy (Zur, 2007). All the concepts mentioned above and in the last section on existential sensitivity imply that an open and dynamic relationship between patient and therapist have a central role. They emphasise the therapists' responsibility for their contribution to this relationship, which requires thorough self-reflection and a constant awareness of the effects that the different aspects of the therapists' identity may have on the interaction. These aspects include reflections on the therapists' religious and spiritual identity (Magaldi & Trub, 2018).

Again, existential psychology may be a preferable approach for this kind of necessary self-reflection in a Norwegian context. In contrast to direct questions about religion or spirituality, which may be misunderstood as referring to traditional religiosity only, existential questions, such as those mentioned by Binder (2021), are both more specific and more open. Instead of asking "what do you believe?" or "how religious are you?", it may be more appropriate to ask "how do you meet death in your life?", "what do you feel responsible for?", "what does your freedom consist of?", "to whom do you belong?", "where do you find meaning in your life?", and "what is your relationship with your own body and the physical world around you?". These questions can be answered in religious, spiritual, or secular ways, or in a combination of all three.

Therapists' self-reflection is integrated into the preparatory training at universities or discussed in professional courses and seminars, as well as in accompanying supervision and even in a reflective style of in-therapy communication. In the therapy room, existential questions can also be helpful to explore patients' existential orientation. The discussion about a possible "religiosity gap" leads to the question of whether a match between therapists and patients' existential orientation is necessary to avoid a risk for the professional relationship. Researchers have different answers to this question. A client-therapist match can be an advantage for the working relationship, as it can make trust easier (Stephan & Utsch, 2017), but it can also be a challenge, as it can create an illusion of understanding (Post & Wade, 2009). Magaldi and Trub (2018) suggest that an open and respectful invitation to reflect on existential, religious, or spiritual issues is more important than a therapist-client match in religious commitment. Examples from therapy sessions support this claim. Binder (2021, p. 148) describes a dialogue with a client with extremist views and quotes the therapist who successfully initiates a working

relationship by saying: “And now we’re sitting here. Yes, we obviously have different views on a lot of things. But I hear that your life is being very painful.” In accordance with Magaldi and Trub (2018), he emphasises that it is helpful for the therapeutic relationship to acknowledge that both client and therapist can be challenged by the same existential questions, albeit in different ways.

In the course of my own work on this study, I was confronted with the challenge of self-disclosure, not in the form of client-therapist relationship, but in conversations as a researcher with therapists about their religious and spiritual orientation. Judicious self-disclosure as a researcher with a multifaceted spiritual biography elicited more differentiated answers than, for example, simply referring to church membership.

Overall, being visible as not only a professional therapist but also as a human being who is existentially challenged and can, therefore, personally relate to the patient’s existential challenges, can be regarded as helpful for the therapy process. In secular Norway, it seems appropriate to initiate both therapist self-reflection and a dialogue with the patient with reference to the existential domains, as proposed by Binder (2021). However, accomplishing this in an ethically responsible way requires a high degree of self-awareness by the therapists and, therefore, a corresponding amount of training.

University training of existential sensitivity

In the replication study that is part of this thesis, we found only limited efforts to educate Norwegian psychology students in existential psychology and equip them with the skills, knowledge, and attitudes that build the competence for spiritual and religious issues in psychotherapy. This finding is unfortunate, given the growing need for culturally sensitive psychotherapy that necessitates more specific education and training to prepare psychologists for the clinical reality that awaits them. According to research, the existential dimension, which includes religion and spirituality, is relevant to many patients in their recovery processes (Binder, 2021). In addition, therapists, regardless of their religious or spiritual backgrounds, can find this dimension challenging in therapy (Stotz-Ingenlath, 2017).

In secular societies such as Norway, religion and spirituality are generally regarded as private matters. While personal religiosity/spirituality along with personal life experience and age are assumed to be the main components of existential sensitivity competence, as my clinical survey study suggests, health care staff will not be motivated to participate in specialised training. There is an opportunity during university training, at an early stage in psychologists’ careers,

to balance positivistic, natural-science-based psychology with training in existential psychology and an appreciation of the spiritual and religious aspects of human life and suffering. Balanced university training can be the first step towards balanced clinical practice. There are several aspects that should be considered.

Existentially sensitive care can be regarded as a team effort (Paal et al., 2015), but, especially psychotherapists who have to do a significant amount of talking, should be provided with knowledge, supervision, and skill training. Psychotherapists are experts in perception and empathetic communication. This expertise should be used actively in the existential dimension, rather than waiting for patients to address the topic. Researchers suggest special training that includes supervision, reflection on the impact of the therapists' personal spiritual biography on the therapy process (Pargament, 2011), and special techniques and skills (Gladding & Crockett, 2018). A constructivist approach is suggested to maintain professional borders when investigating a patient's world view (Ybañez-Llorente & Smelser, 2014). Theoretical courses in existential psychology and supervision in practical seminars could provide important lessons in the given framework of Norwegian clinical psychology training.

Existential sensitivity can be improved throughout health care; especially anamnestic skills and knowledge related to religion and spirituality seem to be underdeveloped, and training for general awareness and cooperation is recommended. Propositions for such trainings are available for physicians (Griffith, 2010; Kristeller et al., 2005), nurses (Vlasblom et al., 2011), and there are entire programmes for health care institutions that include all professions (Pearce et al., 2019b; Raffay, 2010). Evaluations of such training programmes show that they provide favourable outcomes (Paal et al., 2015). Adaptations of these trainings could be used at Norwegian universities to train psychology students and psychologists throughout their first years of practice.

From the data collected in 2005, Reme et al. discovered a dearth of religious subjects in university psychology courses in Norway and linked it, at least in part, to the conventional psychological scepticism about religion (Reme et al., 2009). The debate on secularisation as well as international and national data on patients' wishes could have raised expectations of modifications in university curricula. Because academic bureaucracies are often slow to change, however, there were no expectations of significant changes in the inclusion of relevant topics in the replication study. It was anticipated that religiousness and spirituality, religious diversity, or religious self-awareness were still not included to a larger extent, and this expectation was confirmed. However, 15 years of academic progress have resulted in some smaller changes,

such as an increase in the number of courses that mention religion in the course description. The university reform since 2020 include more culturally sensitive psychological training, which has resulted in a slight increase in courses that include cultural diversity. However, knowledge and abilities specifically related to religion and spirituality are not explicitly listed in this reform document (Kunnskapsdepartementet, 2020). In contrast, there is a rising interest in spirituality in worldwide psychological studies (Pargament, Mahoney, Shafranske, et al., 2013) and therapy (Heidenreich & Michalak, 2013; Holmberg et al., 2017; Ulland & DeMarinis, 2014), the availability of literature and training manuals (Paal et al., 2015), and the students' interest in religious and spiritual topics in psychology teaching.

Because of the continuing secularisation process in Norway, as in many other nations in Western Europe, and the increasing social diversity since 2005 as a consequence of migration and globalisation, the replication study hypothesized that disrespectful classroom communication toward religion might have decreased, but this is not the case—a tendency reflected in the student data. It may be alarming that sensitivity towards religion and spirituality, at least, does not seem to grow at the same pace as diversity. Religious students especially reported comparable levels of disrespectful communication to what was reported 15 years earlier, and they perceived similarly low levels of religious differentiation in psychology teaching.

This notion contradicts a number of statements and recommendations that concern the reputation of psychology, both as a profession and as part of academia. Psychologists in Norway, and throughout the world, focus on the role of psychology in social debates and contribute to discussions on current topics such as gender equality, human rights, or racism (Madsen, 2010; Vasquez, 2012). Although viewpoints may differ significantly, there seems to be an agreement that contemporary psychology as a branch of the social sciences is relevant when psychologists reflect on social phenomena such as interreligious conflict (Pew Research Center, 2021) and provide treatment for people with existential needs in a secular context (Hvidt & Hvidt, 2019). The future direction of the Norwegian secularisation process does not, however, guarantee the peaceful coexistence of diverse religious and spiritual perspectives; alternative conceivable prospects include escalating tensions and confrontations between divergent beliefs (Repstad, 2020b). Providing future psychologists with university-level training in cultural sensitivity, particularly religious and spiritual sensitivity, is crucial to the involvement of psychology in positive societal change.

Moreover, Guest et al. (2017) note that there is a significant distinction between two types of scientific education related to diversity. The first type fosters knowledge about potential group differences, such as general knowledge regarding different religious traditions or typical elements of migration experiences, and the second, more humanistic type promotes cultural sensitivity and self-awareness in a way that includes personal positioning and equips students with a language that can encourage adequate forms of self-disclosure. The latter would be more closely linked to the competence in question. It remains to be determined whether scientific or humanistic instruction now predominates in the limited area allocated to teaching topics such as religion and spirituality in clinical psychology training in Norway. In any case, an increase in awareness training is recommended.

Conclusion

With the background of an international academic discussion on spiritual and religious needs in psychotherapy, this thesis focussed on two specific issues, namely, first, the role of the therapists, their experience with spiritual and religious issues in the therapy room, and their existential competence (including university education) and, second, the role of psychotherapy in the secular health care system of Norway. Both were identified as underrepresented research topics in psychological research, which, thus far, has focussed mainly on patients' needs instead of therapists' contributions and only rarely on the special situation of Norwegian mental health care. Consequently, the question addressed was: ***"Which role do religion and spirituality have in Norwegian psychotherapy?"***

After utilising a mixed-methods approach on data acquired from a number of relevant samples, I can provide an answer to this question comprised of a combination of supplemental perspectives. In addition to a literature review, the answer draws on three datasets, namely a) a comparison of different professional groups in mental health care in Southern Norway, regarding their self-reported spiritual care competence, b) in-depth interviews with practitioners who work integratively with spiritual and religious issues in psychotherapy, and c) psychology students' responses to a survey regarding religion and spirituality in university training. Summarising these different viewpoints, the answer is that ***Religion and spirituality in Norwegian psychotherapy can be considered to be topics with untapped potential, which are causing negative reciprocal inhibition between patient and therapist and becoming increasingly relevant as part of culturally sensitive psychotherapy—a neglected but growing field. It not only deserves more attention, but is also starting to receive it, and there is reason to believe that it will have a positive impact on the quality of psychotherapy in Norway.***

Although the representativity of this research is limited, the mixed-methods approach provides some validity to support the above claim; the quantitative and qualitative studies that are part of this thesis have overlapping and supplementary results, concerning both the importance of the spiritual dimension in psychotherapy and the hesitant attitude of many professionals.

The reviewed literature as well as the results of the empirical research in this thesis converge in three topics that can be presented and linked with recommendations, namely terminology (and how to talk about spirituality and religiosity in research and in therapy), existential health care competence (and how to train psychotherapists), and spiritual self-disclosure (and how to respect both ethical borders and spiritual needs in therapy).

Terminology

The choice of words sets the tone, in both research and therapy. Religion and spirituality seem to be especially vulnerable topics in this respect, as certain terms can be loaded with certain meanings and have connotations to certain traditions, so that misunderstandings can easily occur.

This thesis had to deal with both the shifts in terminology in research that occurred during the last decades of academic dialogue among psychological researchers and different attitudes of the practicing psychologists who participated in the studies and reacted to the choice of words in the surveys and interviews. The academic dialogue, starting with "psychology of religion" and an extremely religious-focussed approach by pioneers such as William James (1902 (1985)) and Sigmund Freud (1927) became ever more differentiated as time passed. The word "religion", for example, has been criticised for being inappropriate for psychological research, and "religiousness" is now preferred by many, as the term describes human behaviour rather than cultural and social frameworks (Paloutzian & Park, 2021). However, "religiousness" only fits partially in research conducted in a secular society such as Norway (Furseth et al., 2019), with growing numbers of people who might describe themselves as "spiritual but not religious" and others who prefer not to describe themselves as spiritual at all but as open to existential issues or interested in Eastern philosophy. Cultural differences between the US, where most of the research in the field originate from, Europe, and the rest of the world add to the terminological complexity, as, for example, "spirituality" has different associations in different cultures (Stifoss-Hanssen, 1999).

In the studies that contribute to this thesis, participants reflected on the range of terms used in the surveys and interviews. Most notable was the reaction of psychology students who were presented with the question of how religious they are. Fifteen years ago, the students answered the question without many comments, but, in the replication study, numerous participants could no longer relate to the terminology and felt the need to comment on it with typically secular statements, such as "my spirituality is a subjective and often-changing experience" or "I would not call myself religious, but open to many things between heaven and earth". In addition, also for the mental health professionals who answered survey questions, the words "religion" or "spiritual needs" provoked differing and strong reactions that became apparent in free text answers such as "wonderful that you address this important topic" or "what a completely meaningless and dumb survey". In the qualitative part of the study, the participants, although quite unanimous in their reception of the spiritual domain as important, would stress the

different terms with which they could identify. These differences in the reactions reflect both research on secularisation in Europe in general and in Scandinavia specifically (Hvidt & Hvidt, 2019), and the strong personal significance of religion and spiritual struggles in the lives of psychological professionals (Magaldi-Dopman et al., 2011).

One key insight from this thesis is the importance of an open, inviting terminology in research as well as in psychological practice to allow for different personal and cultural nuances in the spiritual and religious domain. Wording that run the risk of causing resistance due to the connotations to ambivalent biographical experiences among patients, psychologists, and researchers alike is not suitable. Existential terminology, however, can serve as a container language to allow for equally sensitive and valuable subject matters such as belief, hope, death, belonging, guilt, meaning, and peace. Existential terminology includes and exceeds religiousness and spirituality that is bound to specific traditions and cultures. The Norwegian research centre that was formerly known as "Research Centre for Psychology of Religion" has recently been renamed as "Research Centre for Existential Health"[3], probably as a result of the same line of argument.

Further research related to this argumentation could focus on existential terminology that is appropriate to comprise religious, spiritual, and secular identifications in diverse societies. Suggestions for an adapted set of questions to categorise participants in future surveys, such as the European Social Survey (ESS), could be of equal interest in the development of a set of standard questions that could be taught to psychologists to use in anamnesis interviews and that correlate to the questions suggested for physicians (Kristeller et al., 2005).

Existential health care competence

The measurement, training, and practice of spiritual care have been discussed internationally, initially in palliative care contexts. Subsequently, there have been efforts to widen the scope to general health care. Research in spiritual care competences in mental health care, however, especially in psychotherapy, has been scarce. Pearce et al. (2019a) designed and evaluated a training programme for mental health care professionals in the US context, which address a set of knowledge, skills, and attitudes. Frick et al. (2020) analysed obstacles and possibilities in a German setting. No studies have been done on this aspect in Norwegian mental health care, despite its clinical relevance. International research suggests that spiritual care competence in mental health may have an important impact on the quality of caregiving, as many

[3] https://sykehuset-innlandet.no/avdelinger/alderspsykiatrisk-avdeling/forskningssenter-for-eksistensiell-helse

psychological conflicts and mental disorders are, at least partially, spiritual in origin and/or expression (Pomerleau et al., 2020). Terminological reflections suggest that "existential health care" would be a more appropriate term.

The results of this mixed-methods research shed some light on the situation in Norway. Self-reported levels of competence seem relatively low, comparable to those in Germany. Even though attitudes towards open dialogues with patients about religion and spirituality seem relatively positive, there seems to be a lack of knowledge and skills. Free text answers as well as interview material suggest that, in the perception of health care professionals, existential health care competence is related to personal faith and life experience. The experts who participated in the interview study reported unanimously that they drew on other sources than their university training to address religion and spirituality professionally in psychotherapy. This is supported by the replication study on religion and spirituality as topics in university psychology education; 15 years after the first survey, religiosity is still a neglected topic in university psychology.

However, there are two factors that provide reason for optimism. First, the consistently keen interest in the topic by students who might have shifted focus in an increasingly secular society. The increasing social diversity may render religiosity as one of many important factors of the human experience that is worth studying instead of being perceived as part of a dominant culture students have to fit into. Second, the increasing need for psychotherapy that is sensitive to cultural diversity, including religious and spiritual diversity. This need has been politically recognised and has led to the first reformations in psychological curricula (Kunnskapsdepartementet, 2020).

One key recommendation from the data analysis in this thesis is that the existential domain should receive more attention in the training of clinical psychologists. Patients who struggle with questions of meaning, belonging, guilt, or faith in the course of a mental health crisis, or even experience existential struggles at the core of their suffering, might express this in a religious, spiritual, or secular language. Whatever their stance, they need therapists who are trained to address these topics in a respectful and non-judgemental way. The corresponding competence in psychotherapy is therefore competence in existential thought and dialogue. University training can provide candidates with knowledge, self-reflection, and skill training.

Future research may focus on the same direction and aim to identify actual existential needs and challenges in a rapidly changing society and appropriate psychological language to address

these needs. Clinical psychology and psychiatry could elaborate on the existential challenges connected with specific diagnoses and prepare therapists to deal with them (Stotz-Ingenlath, 2017).

Self-disclosure

One challenge that emerged in both the literature review and the data in this thesis is the appropriate degree and form of therapist self-disclosure. In contrast to the classical psychoanalytical ideal of the professional distance and near-invisibility of the therapist (Freud, 1912), it has become evident that many facets of the therapist's identity become apparent and, therefore, influential from the first moment of a therapeutic process, both consciously and subconsciously (Henretty & Levitt, 2010). At least two factors must be balanced; on the one hand, the therapists' ethical responsibility, to clarify the professional role of the therapist and to attempt to decrease possible manipulation of patients' psychological processes and, on the other hand, the positive effects of an authentic relationship and the necessity of coping with diversity in the therapy room.

In the context of this research, the challenge can even be extended to the role of the researcher and the appropriate amount of contextual information. In psychological research, especially in qualitative studies, there seems to be a tendency to use first person pronouns (Wheeler et al., 2021) and to provide more information about the researcher to increase the sense of trustworthiness and reflexivity (Finlay, 2002). Simultaneously, analytical distance must remain a core element of academic writing, in contrast to journalism or fiction. Zur (2009) proposes a distinction between harmful border violations and helpful boundary crossings in therapy and a reflective, active decision as to what to disclose to whom in which context. This approach can easily be transferred to research; unnecessary autobiographical information or journalistic style can be identified as inappropriate, while personal information about the researcher that is related to the research question, the choice of methods. or the interpretation of the results can enhance the quality of a study by providing some information about possible bias and specific perspectives that inform the discussion. I attempted to do this in the introduction to this thesis by providing some information about my personal and professional motivations.

Spiritual and religious self-disclosure or, in a wider sense, existential self-disclosure in therapy and research can be regarded as a special form of identity self-disclosure since spirituality and religiosity are facets of cultural identity alongside other elements such as nationality, ethnicity, age, or gender. This thesis especially highlights existential issues, namely religion and

spirituality, but it is important to stress that the discussion of the results and any recommendations are best understood under the wider perspective of cultural diversity. Therapists (and researchers alike) in an increasingly diverse society must be aware of different aspects of diverse, individual, and cultural answers to existential questions that arise. This includes diversity in the therapy room and the competence to treat them appropriately, for example, by talking about differences in beliefs or world views.

The data in this thesis highlight several aspects that are relevant in this context, as they suggest that situations of spiritual and religious diversity, and, thus, opportunities for competent self-disclosure, may occur quite regularly in Norwegian mental health care. The quantitative studies revealed a significant religiosity gap (that means existential diversity) between psychologists and patients in mental health clinics, which was also apparent in the comparison of the psychology students and the general Norwegian population. Moreover, students reported unsatisfactory teaching on ways to address religious diversity. In the qualitative study, the therapists displayed a considerable amount of uncertainty regarding the question of spiritual and religious self-disclosure, mainly related to official statements that discourage self-disclosure.

One main recommendation that emanated from these results is that psychologists as well as other mental health care professionals should be trained in appropriate forms of self-disclosure, also regarding existential issues such as religiousness and spirituality. In this sense, existential health care competence should be more than just *knowing* about possible differences, having the *skills* (for example a set of questions) to address existential issues, and having an *attitude* of open-mindedness and respect for diversity. To be able to use knowledge, skills, and attitudes professionally, a reflected awareness of personal religious and spiritual biography is of central importance. University training and supervision for psychotherapists should, therefore, include elements of existential self-reflection that increase awareness of related issues and aid the development of a therapeutic language of self-disclosure that is both respectful and inviting, to help patients to become aware of possible spiritual struggles and/or use the important resource of personal spirituality in their process of healing.

Self-reflection in combination with practical self-disclosure training and theoretical education on ethical challenges seems to be a task that requires some time, and different forms of teaching are possible. Future research could focus on effective forms of teaching and training that meet the interests and needs of students as well as the requirements of the patients in clinical mental

health care. Other research could focus on how psychotherapy patients, especially in Norway, experience different forms of spiritual or religious self-disclosure and existential dialogue.

Summary

Merging the three fields of terminology, existential health care competence, and self-disclosure as core topics in the reflection of the thesis results, I conclude as follows.

To ensure an appropriate role for religion and spirituality in professional psychotherapy in Norway, it would be helpful to establish an existential vocabulary in psychological teaching and practice. Talking about meaning, belonging, death, values, and responsibility in the context of mental health can open the field to resources that are available in religiousness and spirituality as well as increase awareness of spiritual and religious struggles as sources of suffering. Existential health care competence includes both the ability to address existential issues and sensitivity toward spiritual and religious diversity as part of a wider cultural diversity. However, therapists require more than knowledge, attitudes, and skills; they require the ability to position themselves in the diverse field of religion and spirituality, decide on appropriate ways of self-disclosure, and invite their patients to an open and explorative dialogue on religion and spirituality as possible reasons of suffering or as resources on their way to healing. Norwegian psychotherapists deserve appreciation for their professional dedication in many fields, and they will be even better when they gain confidence in stepping carefully on sacred ground.

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Appendix

Surveys and interview guides

Spiritual Care Competence Questionnaire, Norwegian Version

Spørreskjema til opplevd eksistensiell kompetanse innen helsefaglige yrker (SCCQ)

Vennligst les nøye gjennom spørsmålene på de følgende tre sidene og forsøk spontant og uten lang betenkning å finne et svar og en passende avkrysning av skjemaet (vennligst sett kun ett kryss ved hvert spørsmål). Vi ønsker at du besvarer alle spørsmålene – likevel kan du selvfølgelig avstå fra å besvare enkeltspørsmål om du skulle ønske det.

Kjønn: ☐ kvinne ☐ mann ☐ vil ikke svare

Alder: ..... år

Sivilstand: ☐ gift ☐ samboer
☐ skilt ☐ enslig ☐ enke/enkemann

livssyn/religionstilhørighet:

☐ den norske kirke/protestant ☐ muslim ☐ human-etisk forbund ☐ jødisk ☐ katolsk

☐ annet: ..... ☐ ingen

Jeg er (aktivt) troende: ☐ ja, helt klart ☐ ja, litt ☐ nei ☐ nei, slett ikke

Jeg ber/mediterer: ☐ ja, regelmessig ☐ av og til ☐ sjelden ☐ nei, slett ikke

Profesjon: ☐ lege ☐ sykepleier ☐ psykolog ☐ annet: .....

Fagområde: ☐ indremedisin ☐ kirurg/ortoped ☐ geriatri/palliativ medisin
☐ pediatri ☐ gynekologi/barsel ☐ psykiatri/psykoterapi
☐ annet: .....

Yrkesaktiv siden: ..... år

Gjennomsnittlig arbeidstid? ..... timer per uke

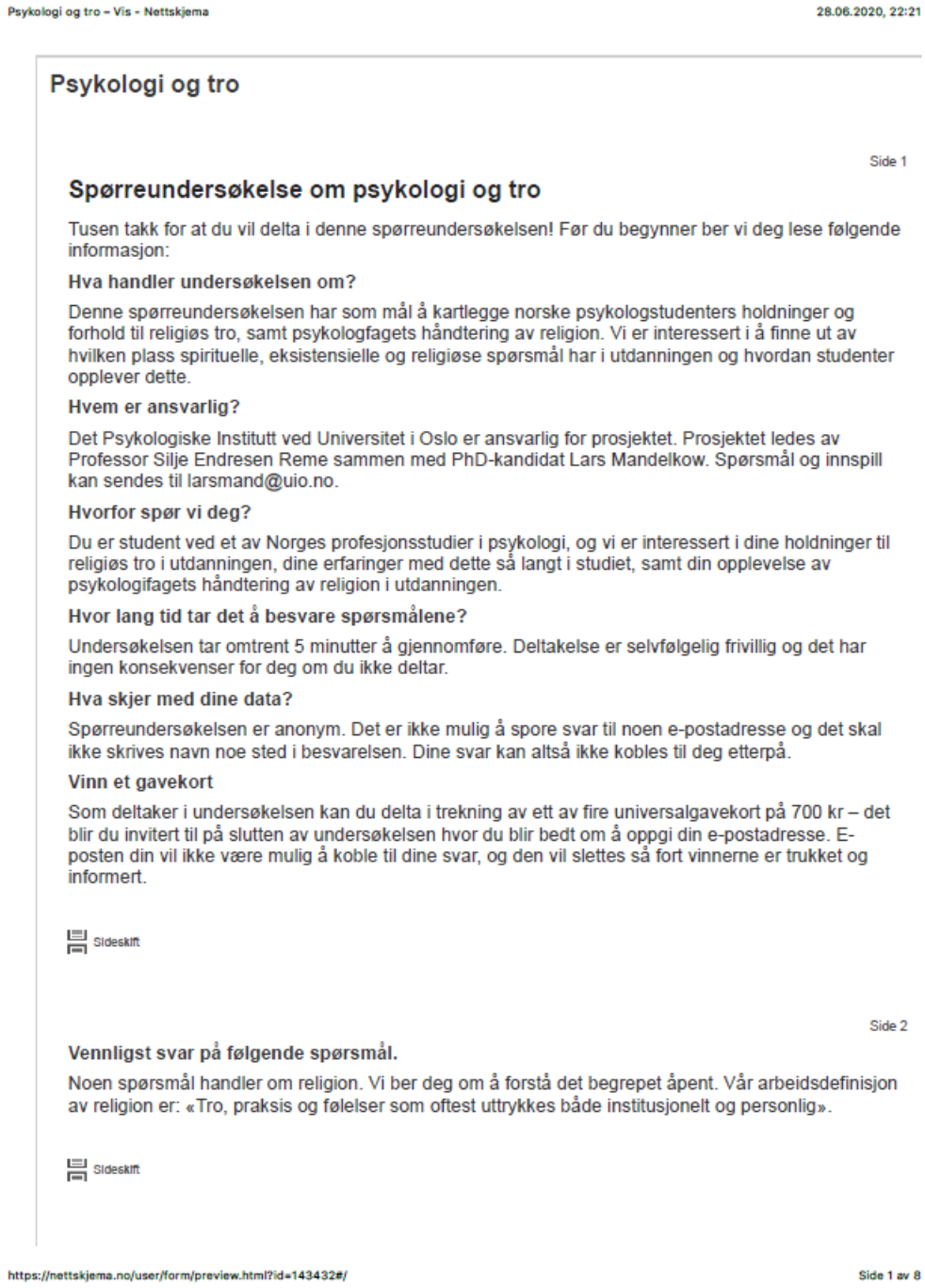
Yrkestilfredshet: ☐ svært tilfreds ☐ tilfreds ☐ midt på treet ☐ misfornøyd ☐ svært misfornøyd

	Vennligst vurder hvor godt de følgende utsagnene passer for deg personlig og kryss av tilsvarende. Vær så ærlig som mulig, for det finnes ingen «riktige» eller «gale» svar.	Utsagnet stemmer…			
		ikke	knapt	godt	presist
1	Jeg tror at jeg er i stand til å gjøre meg kjent med pasienters spirituelle behov.	0	1	2	3
2	Jeg tror at jeg er i stand til å gjøre meg kjent med pårørendes spirituelle behov.	0	1	2	3
3	Jeg kjenner til hjelpemidler (f. eks. temaliste) til å gjøre en enkel kartlegging av pasientens spirituelle ressurser og behov.	0	1	2	3
4	Jeg kjenner til hjelpemidler/spørreskjema til å strukturere oppfatningen av spirituelle behov.	0	1	2	3
5	Jeg vet hvordan jeg på en god og etterprøvbar måte kan dokumentere mine pasienters spirituelle anamnese	0	1	2	3
7	Jeg kan oppfatte eksistensielle og spirituelle behov også når pasientene har lite befatning med religion.	0	1	2	3
8	Jeg kan også snakke med pasienter som har et fjernt forhold til religion om deres eksistensielle og spirituelle behov.	0	1	2	3
12	Vi snakker regelmessig i teamet om pasientenes spirituelle behov.	0	1	2	3
13	I vår avdeling (praksis, klinikk, osv.) har vi stor åpenhet for temafeltet spiritualitet.	0	1	2	3
14	I vårt team utveksler vi regelmessig tanker om temaet spiritualitet i pasientoppfølgingen.	0	1	2	3
15	I teamet utveksler vi regelmessig tanker om vår egen spiritualitet.	0	1	2	3
16	Det er ubehagelig for meg å snakke om spirituelle temaer.	0	1	2	3
17	I gruppen har vi ritualer (f. eks. avskjeds- og avbruddsritual) for å håndtere problematiske situasjoner sammen.	0	1	2	3
19	Jeg er i stand til å føre en åpen samtale om eksistensielle temaer.	0	1	2	3
20	Jeg er i stand til å føre en åpen samtale om religiøse temaer.	0	1	2	3
23	Når jeg ser tilbake på dagen min, tenker jeg regelmessig på mine pasienter.	0	1	2	3
24	Jeg gir mine pasienter mulighet til å delta i religiøse handlinger/feiringer.	0	1	2	3
25	Ved terapeutiske avgjørelser tar jeg hensyn til pasientens religiøse/spirituelle innstillinger, holdninger og overbevisninger.	0	1	2	3
26	Jeg støtter mine pasienter i å reflektere over sine spirituelle overbevisninger og holdninger.	0	1	2	3
28	Jeg er i stand til å holde ut pasientens og deres pårørendes smerter/lidelse.	0	1	2	3
29	Jeg er tilstede med mine tanker og følelser hos de menneskene jeg har omsorg for.	0	1	2	3
30	Min egen spiritualitet preger min omgang med andre/syke mennesker.	0	1	2	3
31	Min egen spiritualitet/religiøsitet har ingen som helst betydning for mitt yrke.	0	1	2	3
32	Jeg har mulighet for å ta avbrudd i hverdagen for min personlige spiritualitet eller trospraksis (f. eks. bønn, meditasjon, stillhet).	0	1	2	3
34	Jeg skulle gjerne hatt mer tid til å snakke med mine pasienter om deres spirituelle behov.	0	1	2	3
35	Jeg passer på å ha egnede rammer for spirituelle samtaler.	0	1	2	3
38	Jeg kjenner godt til hvilke religiøse særegenheter man må ta hensyn til overfor pasienter fra andre trossamfunn.	0	1	2	3
39	Jeg passer på at det som er spesielt for pasienter fra andre trossamfunn blir tatt tilbørlig hensyn til.	0	1	2	3
41	Jeg kjenner til egnede kontaktpersoner (f. eks. kristne, muslimske, jødiske sjelesørgere), som jeg ved behov kan anbefale for bestemte pasientgrupper.	0	1	2	3
42	Jeg henvender meg regelmessig til pasienter for å snakke om deres spirituelle behov.	0	1	2	3
43	Jeg åpner både verbalt og ikke-verbalt et „rom" hvor pasienten kan ta opp spirituelle anliggender, men ikke tvinges til det.	0	1	2	3

	Fortsettelse	Utsagnet stemmer…			
		ikke	knapt	godt	presist
44	Jeg vet for lite om religion/spiritualitet til å bidra med noe på en kompetent måte.	0	1	2	3
45	Jeg føler at religiøse/spirituelle temaer ikke er min oppgave.	0	1	2	3
46	Jeg har ikke tid til religiøse/spirituelle temaer.	0	1	2	3
47	Det finnes ikke noe egnet rom for å kunne snakke om spirituelle temaer (som jo er private) i trygge rammer.	0	1	2	3
48	Jeg sørger regelmessig for å fordype min egen spiritualitet (f. eks. ved stille dager meditasjon, gudstjenestebesøk, osv.).	0	1	2	3
49	Jeg er regelmessig på kurs/samlinger for videreutvikling i spirituelle temaer.	0	1	2	3
55	Jeg mener det er viktig å være følsom overfor andres lidelse – og være tilstede for den.	0	1	2	3
56	Egne svakheter og sår fremmer ens spirituelle kompetanse.	0	1	2	3
57	Jeg synes at min yrkesgruppe besitter en spesiell eksistensiell kompetanse.	0	1	2	3
58	Fordi:				
59	Jeg synes at min yrkesgruppe ikke er egnet for å tilby eksistensiell omsorg.	0	1	2	3
60	Fordi:				

Tusen takk!

Survey on religion in university psychology in Norway



Psykologi og tro – Vis - Nettskjema 28.06.2020, 22:21

Psykologi og tro

Side 1

Spørreundersøkelse om psykologi og tro

Tusen takk for at du vil delta i denne spørreundersøkelsen! Før du begynner ber vi deg lese følgende informasjon:

Hva handler undersøkelsen om?

Denne spørreundersøkelsen har som mål å kartlegge norske psykologstudenters holdninger og forhold til religiøs tro, samt psykologfagets håndtering av religion. Vi er interessert i å finne ut av hvilken plass spirituelle, eksistensielle og religiøse spørsmål har i utdanningen og hvordan studenter opplever dette.

Hvem er ansvarlig?

Det Psykologiske Institutt ved Universitet i Oslo er ansvarlig for prosjektet. Prosjektet ledes av Professor Silje Endresen Reme sammen med PhD-kandidat Lars Mandelkow. Spørsmål og innspill kan sendes til larsmand@uio.no.

Hvorfor spør vi deg?

Du er student ved et av Norges profesjonsstudier i psykologi, og vi er interessert i dine holdninger til religiøs tro i utdanningen, dine erfaringer med dette så langt i studiet, samt din opplevelse av psykologifagets håndtering av religion i utdanningen.

Hvor lang tid tar det å besvare spørsmålene?

Undersøkelsen tar omtrent 5 minutter å gjennomføre. Deltakelse er selvfølgelig frivillig og det har ingen konsekvenser for deg om du ikke deltar.

Hva skjer med dine data?

Spørreundersøkelsen er anonym. Det er ikke mulig å spore svar til noen e-postadresse og det skal ikke skrives navn noe sted i besvarelsen. Dine svar kan altså ikke kobles til deg etterpå.

Vinn et gavekort

Som deltaker i undersøkelsen kan du delta i trekning av ett av fire universalgavekort på 700 kr – det blir du invitert til på slutten av undersøkelsen hvor du blir bedt om å oppgi din e-postadresse. E-posten din vil ikke være mulig å koble til dine svar, og den vil slettes så fort vinnerne er trukket og informert.

Sideskift

Side 2

Vennligst svar på følgende spørsmål.

Noen spørsmål handler om religion. Vi ber deg om å forstå det begrepet åpent. Vår arbeidsdefinisjon av religion er: «Tro, praksis og følelser som oftest uttrykkes både institusjonelt og personlig».

Sideskift

https://nettskjema.no/user/form/preview.html?id=143432#/ Side 1 av 8

Psykologi og tro – Vis - Nettskjema 28.06.2020, 22:21

Side 3

Hvilket universitet studerer du ved? *

- UiB
- NTNU
- UiO
- UiT

Sideskift

Side 4

Kjønn *

- Mann
- Kvinne
- Ønsker ikke å svare

Sideskift

Side 5

Semester på profesjonsstudiet i psykologi *

- 1-6
- 7-12

Sideskift

Side 6

Holdninger til at religion blir dekket i psykologutdannelsen:

Jeg anser en åndelig dimensjon, på samme måte som den fysiske og psykiske dimensjon, å være en viktig del av mennesket, og derfor også en viktig del av psykologien *

- Stemmer ikke i det hele tatt
- Stemmer ikke særlig godt

- Stemmer ganske godt
- Stemmer helt

Sideskift

Side 7

Synes du det er for lite fokus på menneskers religiøse tro i psykologutdannelsen? *

- Stemmer ikke i det hele tatt
- Stemmer ikke særlig godt
- Stemmer ganske godt
- Stemmer helt

Sideskift

Side 8

Synes du en større del av pensum bør omhandle religiøse tema? *

- Stemmer ikke i det hele tatt
- Stemmer ikke særlig godt
- Stemmer ganske godt
- Stemmer helt

Sideskift

Side 9

Jeg synes ikke religiøse tema er særlig relevant for psykologfaget *

- Stemmer ikke i det hele tatt
- Stemmer ikke særlig godt
- Stemmer ganske godt
- Stemmer helt

Side 10

Fokus på religion ligger utenfor psykologfagets område *

- Stemmer ikke i det hele tatt
- Stemmer ikke særlig godt
- Stemmer ganske godt
- Stemmer helt

Sideskift

Side 11

Oppfatning av psykologifagets holdning til religion:

Jeg mener at psykologfaget har et nyansert forhold til religion *

- Stemmer ikke i det hele tatt
- Stemmer ikke særlig godt
- Stemmer ganske godt
- Stemmer helt

Sideskift

Side 12

Oppfatning av psykologprofesjonens holdning til troende:

Jeg har opplevd at religiøse mennesker har blitt latterliggjort i undervisningen *

- Stemmer ikke i det hele tatt
- Stemmer ikke særlig godt
- Stemmer ganske godt
- Stemmer helt

Side 13

Nyansert vs stereotypt:

Psykologfagets samlede oppfatning til religiøse mennesker synes jeg er *

- ○ Meget nyansert
- ○ Til dels nyansert
- ○ Nøytralt
- ○ Litt stereotypt
- ○ Meget stereotypt

Sideskift

Side 14

Dekning av religion i utdannelsen:

Har religiøsitet eller tro vært tema i din psykologutdanning? *

- ○ Stemmer ikke i det hele tatt
- ○ Stemmer ikke særlig godt
- ○ Stemmer ganske godt
- ○ Stemmer helt

Sideskift

Side 15

Har religiøsitet eller tro vært tema i din psykologutdanning i form av: *

- ☐ Forelesningsrekke
- ☐ En forelesning
- ☐ Deler av forelesning
- ☐ Pensum, artikler eller bøker

- [ ] Kommentarer eller eksempler
- [ ] Diskusjon mellom studenter
- [ ] Studentorganiserte religiøse grupper og/eller andre tiltak

Sideskift

Side 16

Jeg tilhører: *

- ○ Den norske kirke
- ○ Den romersk-katolske kirke
- ○ Pinsebevegelsen
- ○ Annet kristent trossamfunn
- ○ Islam
- ○ Annet ikke-kristent trossamfunn
- ○ Human-etisk forbund
- ○ Annet livssynssamfunn
- ○ Ikke noe tros- eller livssynssamfunn
- ○ Ønsker ikke å svare

Sideskift

Side 17

Vil du beskrive deg selv som: *

- ○ Veldig religiøs
- ○ Sterkt religiøs
- ○ Litt religiøs
- ○ Hverken religiøs eller ikke-religiøs
- ○ Litt ikke-religiøs

- ◯ Sterkt ikke-religiøs
- ◯ Veldig sterkt ikke-religiøs
- ◯ Annet (spesifiser under)
- ◯ Ønsker ikke å svare

Hvis du svarte "Annet" spesifiser her:

Sideskift

Side 18

Hvor ofte er du til stede ved gudstjenester eller andre religiøse møter? (Regn ikke med bryllup, begravelse, dåp, eller lignende) *

- ◯ Aldri
- ◯ Sjeldnere enn én gang i året
- ◯ Omtrent en til to ganger i året
- ◯ Flere ganger i året
- ◯ Omtrent en gang i måneden
- ◯ to-tre ganger i måneden
- ◯ Nesten hver uke
- ◯ Hver uke
- ◯ Flere ganger i uken
- ◯ Ønsker ikke å svare

Sideskift

Side 19

Hvis jeg trengte psykologisk hjelp ville det vært viktig for meg at psykologen har en kompetanse i spirituelle/religiøse spørsmål *

- ◯ Ja
- ◯ Nei
- ◯ Vet ikke

Tusen takk for du deltok i denne undersøkelsen!

Dersom du vil være med i trekningen av ett av fire universalgavekort på 700 kr, sender du en email til larsmand@uio.no. Send gjerne en tom epost, men skriv "gavekort" i emnefeltet.

Interview guide, qualitative study

Spørsmål til psykoterapeuter som integrerer spiritualitet i sitt arbeid

innledning

- Vennligst fortell litt om din aktuelle arbeidsplass.
- Hva er din utdannelse?

spiritualitet/religiøsitet

- Hvordan forstår du begrepene «spiritualitet» og «religiøsitet»?
- Anser du deg selv som et spirituelt eller religiøst menneske? Hvorfor?
- Har dette forandret seg i løpet av livet? Hvordan?

Spiritualitet og psykoterapi

- Gjennom studium og terapeutisk utdanning, på hvilken måte ble du forberedt på å håndtere spirituelle/religiøse spørsmål?
- Hvilken rolle spiller spiritualitet i ditt psykoterapeutisk arbeid i dag?
  - … i pasientenes liv? Eksempler?
  - … i din egen tilnærming til ditt arbeid? Eksempler?
- Har dette forandret seg i løpet av arbeidslivet? Hvordan?
- Hva slags muligheter/utfordringer oppstår når spirituelle spørsmål får mer plass i terapi? Eksempler?
- Hvordan reagerer dine kollegaer på din holdning?

utdanning/kompetanseutvikling

- Hvordan ville du definert kompetanse i å håndtere spirituelle/religiøse spørsmål i terapi?

utdypende: Hvilken rolle spiller:

- Sin egen biografiske bakgrunn/egenerfaring?
- Kunnskap om egen og andre religioner?
- Holdninger til annerledes former av spiritualitet?
- Særskilte terapeutiske intervensjoner?

- Hvordan har du utviklet din spirituelle kompetanse?
  - Hva slags utdanning for unge psykoterapeuter ville du ønsket (med hensyn til spirituell kompetanse)? Kjenner du til gode eksempler?
  - Hvordan opplever du samarbeid med representanter fra religiøse institusjoner? Hva ville du ønsket? Kjenner du til gode eksempler?

avslutning

- Hva motiverte deg å delta i dette intervjuet?

1

Lars Mandelkow, Ansgar Teologiske Høgskole, 18062019

Data security, participant information and ethical committee statements

Patient information SCCQ study

UiO : Universitetet i Oslo

universität Witten/Herdecke

Ansgar Teologiske Høgskole

Vil du delta i et forskningsprosjekt om
«eksistensiell kompetanse innen helsefaglige yrker»?

Spørsmålene i denne studien handler om hvordan du selv vurderer din eksistensielle kompetanse på jobb. Undersøkelsen er en del av en doktorgradsstudie som bidrar til et større prosjekt i regi av Universitetene i Oslo, München og Witten/Herdecke (Tyskland) og Ansgar Teologiske Høgskole i Kristiansand. Både medarbeiderne i doktorgradsstudien og lederne av den tyske «Forschungsstelle Spiritual Care» skal jobbe med dataene. Vi ønsker å finne ut mer om hvilken rolle spirituelle/eksistensielle/religiøse spørsmål spiller i helsevesenet. Vi er særlig interessert i å høre om det finnes forskjeller mellom de ulike yrkesgruppene i forhold til slike spørsmål. Du er invitert fordi du har kontakt med pasienter eller/og kollegaer i helsetjenesten og er kjent med hverdagen i din yrkesgruppe.

Deltakelse er frivillig. Det vil ta deg 5-10 minutter å besvare spørsmålene. Du blir først bedt om å besvare noen spørsmål om deg selv, deretter om dine erfaringer på jobb. Du kan velge å ikke svare på enkelte spørsmål, og du kan trekke deg når du vil uten å oppgi noen grunn. Om du deltar eller ikke, får ingen negative konsekvenser for deg. Dine svar fra spørreskjemaet blir registrert elektronisk.

Denne samtykkeerklæringen med navnet ditt på skal oppbevares adskilt fra svarene dine, og blir koblet sammen med hjelp av en kodenøkkel som også oppbevares adskilt. Datamateriale skal brukes kun elektronisk og i avidentifisert form. Du vil altså ikke kunne gjenkjennes i publikasjonene om prosjektet. Vi avslutter prosjektet 2021, svarene på papir vil tilintetgjøres 31.12.2030.
Så lenge du kan identifiseres i datamaterialet, har du rett til innsyn i hvilke personopplysninger som er registrert om deg, å få de rettet, slettet eller utlevert som kopi. Du kan også sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Vi tar ditt personvern alvorlig. Derfor bruker vi dine svar bare hvis du har undertegnet denne samtykkeerklæringen. Studien er meldt til Personvernombudet for forskning, Norsk Senter for Forskningsdata (NSD), som har vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvis du har spørsmål til studien eller ønsker å benytte deg av dine rettigheter, ta kontakt med mandelkow@ansgarskolen.no eller NSD personvernombudet@nsd.no (tel. 55 58 21 17).
Tusen takk for at du vil delta!

Med vennlig hilsen

Lars Mandelkow
prosjektansvarlig psykolog

Samtykkeerklæring

Jeg har lest og forstått informasjonen om prosjektet «eksistensiell kompetanse innen helsefaglige yrker». Jeg samtykker til å delta i spørreskjemaundersøkelsen og at mine opplysninger behandles frem til prosjektet er avsluttet ca. 31.12.2021.

X _____

Navn og signatur prosjektdeltaker, dato

Patient information qualitative study

UiO : Universitetet i Oslo

Vil du delta i et forskningsprosjekt om «psykoterapi og spiritualitet»?

Du inviteres med dette til et intervju om dine erfaringer som psykoterapeut. Spørsmålene vil handle om hvordan du opplever sammenhengen mellom spiritualitet og terapi. Undersøkelsen er en del av mitt doktorgradsstudium, som er tilknyttet Universitetet i Oslo og Ansgar Teologiske Høgskole i Kristiansand. Jeg ønsker å finne ut mer om hvilken rolle psykoterapeuters egne spirituelle/religiøse holdninger og erfaringer spiller i terapirommet, hva slags kompetanse det finnes for å håndtere spirituelle spørsmål i psykoterapi og hvordan den kompetansen kan oppbygges. Du inviteres til å delta fordi du jobber som psykoterapeut og har vist faglig interessere for spirituelle spørsmål.

Deltakelse er selvfølgelig frivillig. Et intervju vil ta omtrent 1 time. Du vil først bli bedt om å besvare noen spørsmål om deg selv, deretter om dine erfaringer på jobb og dine tanker knyttet til forskjellige aspekter ved religion/spiritualitet i psykoterapi. Du kan velge å ikke svare på enkelte spørsmål, og du kan trekke deg når som helst uten å oppgi noen grunn. Om du deltar eller ikke, får selvfølgelig ingen negative konsekvenser for deg. Intervjuet vil bli tatt opp på en lydfil og senere transkribert til en tekstfil. Både lyd- og tekstfil oppbevares på en server med passordbeskyttet tilgang.

Denne samtykkeerklæringen med navnet ditt påført vil bli oppbevart kun på papir og adskilt fra tekst og lydfiler, som vil bli koblet sammen ved hjelp av en kodenøkkel. Datamateriale vil bli analysert i avidentifisert form, dvs. at bakgrunnsopplysninger som kunne muliggjøre personlig identifikasjon skal generaliseres. Du vil altså ikke kunne gjenkjennes i publikasjonene fra prosjektet. Jeg avslutter prosjektet 2023, filene vil bli slettet 31.08.2029.
Du har rett til innsyn i hvilke personopplysninger som er registrert om deg, å få de rettet, slettet eller utlevert som kopi. Du kan også sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Jeg tar ditt personvern på alvor. Derfor bruker jeg bare dine svar dersom du har undertegnet denne samtykkeerklæringen. Studien er meldt til Personvernombudet for forskning, Norsk Senter for Forskningsdata (NSD), som har vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvis du har spørsmål til studien eller ønsker å benytte deg av dine rettigheter, ta kontakt med mandelkow@ansgarskolen.no eller NSD personvernombudet@nsd.no (tel. 55 58 21 17).
Tusen takk for at du vil delta!

Med vennlig hilsen

Lars Mandelkow
prosjektansvarlig psykolog

Samtykkeerklæring

Jeg har lest og forstått informasjonen om prosjektet «spirituell kompetanse i psykoterapi». Jeg samtykker til å delta i intervjuet og at mine opplysninger behandles frem til prosjektet er avsluttet ca. 31.08.2023.

X _____

Navn og signatur prosjektdeltaker, dato

Data security report NSD SCCQ study

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Measuring of Spiritual Care Competence in Sørlandet Sykehus, using SCCQ (Spiritual Care Competence Questionnaire)

Referansenummer

705373

Registrert

09.10.2018 av Lars Mandelkow - lars.mandelkow@googlemail.com

Behandlingsansvarlig institusjon

Ansgar Teologiske Høgskole

Prosjektansvarlig

Lars Mandelkow, mandelkow@ansgarskolen.no, tlf: 40659364

Felles behandlingsansvarlige institusjoner

Type prosjekt

Forskerprosjekt

Prosjektperiode

10.10.2018 - 31.12.2021

Status

09.01.2019 - Vurdert

Vurdering (1)

09.01.2019 - Vurdert

Det er vår vurdering at behandlingen vil være i samsvar med personvernlovgivningen, så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet med vedlegg, samt i meldingsdialogen mellom innmelder og NSD, den 09.01.19. Behandlingen kan starte.

MELD ENDRINGER
Dersom behandlingen av personopplysninger endrer seg, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. På våre nettsider informerer vi om hvilke endringer som må meldes. Vent på svar før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle særlige kategorier av personopplysninger frem til 31.12.21.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.
Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 a), jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER
NSD finner at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen:
- om lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
De registrerte vil ha følgende rettigheter i prosjektet: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).
Rettighetene etter art. 15–20 gjelder så lenge den registrerte er mulig å identifisere i datamaterialet.
NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.
Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

Technische Universität München og Universität Witten/Herdecke er felles behandlingsansvarlige institusjoner samme med Ansgard Teologiske høgskole. NSD legger til grunn at behandlingen oppfyller kravene til felles behandlingsansvar, jf. personvernforordningen art. 26. Det må foreligge avtaler mellom partene.

For å forsikre dere om at kravene oppfylles, må prosjektansvarlig følge interne retningslinjer/rådføre seg med Ansgard Teologiske høgskole.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp ved planlagt avslutning for å avklare status for behandlingen av personopplysninger.

Lykke til med prosjektet!

Kontaktperson hos NSD: spesialrådgiver Kjersti Haugstvedt
Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Data security report NSD qualitative study

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Ekspertintervju om spiritualitet i psykoterapi

Referansenummer

874868

Registrert

24.06.2019 av Lars Mandelkow - lars.mandelkow@googlemail.com

Behandlingsansvarlig institusjon

Ansgar Teologiske Høgskole

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Lars Mandelkow, mandelkow@ansgarskolen.no, tlf: 40659364

Type prosjekt

Forskerprosjekt

Prosjektperiode

01.08.2019 - 31.08.2023

Status

02.07.2019 - Vurdert

Vurdering (1)

02.07.2019 - Vurdert

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet den 02.07.2019 med vedlegg. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde:
https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html
Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle særlige kategorier av personopplysninger om religion og alminnelige kategorier av personopplysninger frem til 31.08.2023. Data med personopplysninger skal deretter lagres for videre

forskning internt ved behandlingsansvarlig institusjon, frem til 31.08.2029.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 a), jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/ pågår i tråd med den behandlingen som er dokumentert.

Lykke til med prosjektet!

Kontaktperson hos NSD: Jørgen Wincentsen
Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Ethical committee evaluation student study

UiO : University of Oslo
Faculty of Social Sciences – Departement of Psychology

Silje Endresen Reme

Ref.number: **6137156**
Date: 20 September 2022

Ethical evaluation of research project

Your project, "Religious Attitudes and Experiences among Norwegian Psychology Students: A replication study" has been ethically evaluated by the Department of Psychology's internal research ethics committee.

After the evaluation The Department of Psychology's internal research ethics committee recommend the project.

Sincerely yours, on behalf of the Committee,

Professor Lars Tjelta Westlye, Head of Research
Members of the Department of Psychology's Research Ethics Committee
https://www.uio.no/for-ansatte/enhetssider/sv/psi/psi-eng/internal-ethics-committee/index.html