

Exploring Religious Meaning-Making in Individual  
Psychotherapy

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**Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.



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## Overview

As humans, we must make sense of our experiences in order to find meaning and purpose in life, especially during times of difficulty. Religion can play a significant role in this process of meaning-making, and has been implicated in how people understand and cope with suffering. Part One of this thesis provides a theoretical overview of extant literature pertaining to meaning-making, religion, and mental health.

Historically, research on these topics has correlated religiosity with psychotherapeutic outcomes, and explored therapists' perspectives on the incorporation of religion in therapy. However, little work has been conducted with religious service users to understand how they make sense of their mental health difficulties, and the ways in which this was explored in their individual therapy. Part Two of this thesis presents an Interpretative Phenomenological Analysis study exploring five religious mental healthcare service users' experiences of their faith, mental health difficulties, and psychotherapy.

This thesis was produced alongside an Expert by Experience who provided input in all stages of research development, governance, data analysis, and write-up. The complexities and implications of coproduction for trainee research are explored in Part Three of the thesis. Part Three also discusses quality in qualitative research, and applies existing guidance to the empirical work presented in Part Two in an attempt to critically evaluate the quality of this study.

## **Impact Statement**

Religion is a central meaning-making framework for billions of people in the world, providing solace and hope during times of difficulty. Religiosity is associated with better mental health in the general population, and better psychotherapeutic treatment outcomes within healthcare services. Psychotherapy is inherently a meaning-making endeavour; therapists support service users to explore and understand their experiences in order to improve their coping and wellbeing for the future. Recent world events such as the murder of George Floyd and the covid-19 pandemic have highlighted stark inequalities in modern society. Consequently, there has been a surge in interest within clinical psychology to increase cultural competence, and meaningfully incorporate social differences into therapy. This comes with the acknowledgement that service users' voices need to be better represented in clinical research, and that therapists require greater support in navigating power and privilege in the therapeutic space. Many individuals who seek psychotherapeutic intervention are religious, and yet this is rarely discussed in therapy – despite the centrality of religion to their meaning-making.

Part One of this thesis provides a rationale for incorporating religion in psychotherapy. This is followed by an exploration of existing theories linking meaning-making, religion, and therapy. The aim of this paper is to synthesise literature pertinent to religion and therapy in order to theoretically inform psychotherapeutic practice. The final section of this chapter outlines key ontological and epistemological considerations for religion in therapy and clinical research. The anti-theism inherent in much of clinical psychology theory, research, and practice is highlighted to guide clinicians to critically examine their own ideological positioning. It is hoped that this will support clinicians to develop a more holistic understanding of religion as it relates to therapy.

Part Two of the thesis presents a qualitative study exploring religious mental healthcare service users' experiences of mental health and psychotherapy. The aim of this paper is to foreground service users' perspectives on a topic which has historically focused on therapists' experiences. Findings indicated that religious mental healthcare service users

want to discuss their religion in therapy without fear of judgement from therapists. This chapter provides clear suggestions for clinical practice; it is hoped that this will provide clinicians with a greater understanding of the ways in which religion and mental health are linked in order to improve clinical practice, and hence service users' experiences. The intention is to improve therapists' confidence and competence in discussing religion to create more open and accepting therapeutic spaces for service users with diverse lived experiences.

Part Three of the thesis discusses the adoption of a coproduction approach for trainee research, with a critical reflection on the challenges posed by this. It is hoped that this is useful for future trainees who may be interested in coproduction, and provide specific suggestions that trainees may implement to overcome systemic and procedural barriers. The final section of this chapter systematically explores the quality of the empirical paper using existing frameworks and guidelines. It is intended that this contributes to a growing understanding of quality in qualitative research within the field of clinical psychology.

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## Part 1: Literature Review

Conceptual Introduction: Religious Meaning-Making of Mental Health

Difficulties in Psychotherapy

## Overview

People make sense of their day-to-day experiences in order to understand their place in the world and move toward a rich and fulfilled life. When challenges occur on this journey, such as the experience of mental health difficulties, the individual must re-interpret their experiences in order to construct a narrative that makes sense to them within their personal context. In individuals with strong religious faith, these meaning-making processes are linked intrinsically to a worldview that includes transcendental being(s). Psychological therapies for individuals experiencing mental health difficulties focus on individuals' meaning-making processes, aim to deconstruct less helpful interpretations, and facilitate the formation of novel understandings that enable the person to helpfully manage their difficulties. Although therapeutic modalities approach meaning-making in vastly different ways, the end-product is often the reduction of distress that occurs through a shift in the individual's relationship to themselves, the world, and the future. Given how significant religion can be, it is important for us to consider how religious meaning-making frameworks influence, and are in turn influenced by, psychotherapeutic processes.

Prior research in this field has tended to fall into two categories: firstly, mental health outcomes (e.g. changes in symptom scores pre- and post-psychotherapy) are correlated with religiosity to understand whether stronger belief in transcendental being(s) is associated with greater improvement in mental health following therapy. Secondly, given that most therapeutic modalities and therapists are secular, research has focused on understanding therapists' beliefs about the incorporation of religion into psychotherapy - including their perspectives on the benefits of and barriers to this. Empirical research assessing the views of religious mental healthcare service users is lacking. This thesis aims to bridge this gap in the literature by exploring service users' religious meaning-making of mental health difficulties, and understanding how these themes were explored in their individual psychotherapy.

The first section of this Conceptual Introduction (CI) outlines the rationale for this research by providing an overview of empirical research on religion, mental health, and

psychological therapy. The second section of the CI provides a theoretical overview of meaning-making processes, mental health difficulties, religion, and the interactions between these in psychological therapy. The final section of the CI explores the proposed methodology for investigating these experiences with participants in Part Two of this thesis, with an explicit focus on the ontological and epistemological positioning taken by this research. It is of note that most psychological theory, research, and practice are grounded in atheistic or anti-theistic paradigms; this CI aims to assimilate a theistic worldview with Interpretative Phenomenological Analysis methodology in order to create a coherent framework to be applied in Part Two of the thesis.

### **Definition of Key Terms**

Prior to proceeding with the content of this chapter, it is important to define key terms such as: religion, spirituality, mental health, and mental health difficulties.

#### **Religion & Spirituality**

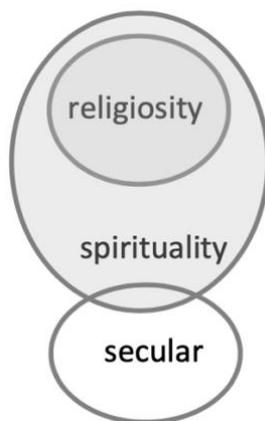
Firstly, it is important to address the contentious issue regarding the terms “religion” and “spirituality”. As Zinnbauer and Pargament (2014) found, individuals who identify as religious or spiritual are reliably able to define these terms and explain the nature of their experiences in relation to these labels - however, academic definitions remain unclear and disputed.

Prior research has shown a tendency for individuals who identify as religious to associate themselves with the social or community-based elements of organised religion, whereas those who identify as spiritual relate more to concepts of transcendence and connectedness (Zinnbauer & Pargament, 2002). However, these dichotomous conceptualisations reduce two overlapping, multi-dimensional concepts into static labels (Zinnbauer & Pargament, 2014). Given this, understandings of religion and spirituality which explore the interrelatedness of religion and spirituality are likely to be more helpful for understanding religious meaning-making processes. There are two main understandings of religion and spirituality that take this non-dialectic stance: that of Pargament - who states that religion encompasses spirituality, and that of Zinnbauer - who states that spirituality

encompasses religion (e.g. Zinnbauer & Pargament, 2014). Both authors provide compelling arguments for these contrasting perspectives, and note that there is no inherent “truth” in either position - the utility of each is context-bound. In this thesis, the positioning of Zinnbauer, who conceptualises spirituality as the broader construct which encompasses religiosity (see Figure 2) is favoured.

## Figure 2

*Conceptualising Religiosity and Spirituality, (Zwingmann et al., 2011)*



This stance is chosen due to consensus both amongst those who have faith and academic psychologists (Zinnbauer & Pargament, 2014) that religiosity is encompassed by spirituality. It is believed this approach will improve the understandability and relatability of the content of this paper to readers.

As Figure 2 shows, spirituality can be understood as a broader concept within which religiosity is contained. This definition acknowledges the overlaps between religiosity and spirituality as well as the differences between them. Zwingmann et al. (2011) note that some elements of spirituality are shared across different religions such as: religious orientation - praying to and trusting in transcendental being(s); searching for insight or wisdom - drawing on philosophical and existential approaches; conscious interactions - practicing compassion, generosity, and forgiveness, and; transcendence conviction - faith in transcendental being(s) or in processes such as rebirth. Simultaneously, there remain elements of religious experience which are not shared by all forms of spirituality - some of which may relate to the

specific practices associated with a particular religion and its adherents e.g. attending Mass, praying five times per day etc.

This thesis focuses specifically on the experiences of people who identify as religious. This is due to three reasons: firstly, based on Zinnbauer's conceptualisation the hope is to access the experiences of individuals with specific religious faith as, by definition, they are also spiritual. Secondly, there has been a global paradigm shift toward atheistic science (Slife & Whoolery, 2006), which has led to the pathologisation and stigmatisation of people who are religious within the field of psychology (Masters, 2010). This has led to an increase in research on "religion / spirituality" whereby these experiences are conflated, and the taboos around religion are not addressed. This work aims to counteract this by focusing explicitly on the experiences of religious individuals.

Thirdly, we focus here on religion in its broadest sense, without focusing on specific religions. This tendency to focus on religious people's experiences without denoting specific religions is a common practice in research. A disadvantage of this approach is its tendency to reduce all diverse religions into one concept, and hence the loss of nuances between different world religions. We do not provide an overview of different world religions in this thesis. This is due to the contextual approach taken which places emphasis on the wider social discourses (Parks & Tracy, 2015) and power dynamics which influence religious individuals' lived experiences.

In our work, we aim to explore the experiences of religious individuals in an increasingly atheistic world, and how this impacts on their understandings of mental health as well as their experiences of psychotherapy. This is due to an explicit focus in this thesis on power (DiAngelo, 2006), oppression (Burnham, 2012), and intersectionality (Crenshaw, 2017). Whilst we acknowledge the role of intersectional experiences (e.g. race and religion), there is a greater emphasis placed on religion in this thesis as religion is the main topic of study. This chapter focuses specifically on religion, mental health difficulties, and therapy in order to orient the reader to this set of intersecting experiences and create a coherent theoretical framework. Part 2 expands on this by taking an intersectional approach, largely

due to the multiple oppressed identities that study participants spoke of in their interviews – such as race, religion, gender, and sexuality.

*In sum*, although those who have faith are reliably able to define religion and spirituality, there has not been much consensus in the academic literature. Whilst previous conceptualisations place religiosity and spirituality in a dialectic, more recent definitions acknowledge their interconnectedness. One such definition, adopted in this thesis, is that of Zinnbauer - whereby spirituality encompasses religion. Following this definition, the focus is explicitly on the experiences of religious individuals in an increasingly atheist world - pushing away from the stigma and taboo around this topic.

### **Defining Mental Health and Mental Health Difficulties**

Mental health difficulties are an example of a chronic stressor which cannot be problem-solved, and hence must be managed through meaning-making processes. Although historically, definitions of mental health focused on the absence of mental ill-health (Galderisi et al., 2015), more recent conceptualisations have shifted to considering mental health as a state of wellbeing in which individuals can realise their abilities, cope with the stresses of life, work productively, and contribute to their community (Dodge et al., 2012). However, these definitions continue to be based on a hedonistic and eudaemonic worldview which does not align with the values and belief systems of the religious (Slife & Whoolery, 2006). Therefore, a novel definition was proposed by Galderisi et al. (2015, pp. 231-232) whereby “mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society”. The authors define “universal values” as “respect and care for oneself and other living beings; recognition of connectedness between people; respect for the environment; respect for one’s own and others’ freedom.” (Galderisi et al., 2015, p. 232). This definition, contrary to previous conceptualisations, allows us to consider mental health in the context of a religious life based on altruism, holism, spirituality, and theism (Bergin & Richards, 2005).

Given this definition of mental health, mental health difficulties can be considered as a process in which the individual struggles to build and sustain a meaningful life which aligns

with their religious beliefs and goals (Park, 2005). Mental health difficulties are one form of suffering; the specific religious beliefs of the individual determine the meaning attributed to mental health difficulties, and hence to the person's responses to that suffering over time.

## **Section 1: What does the existing literature tell us about religion, mental health, and psychotherapy?**

### **What is the rationale for studying religious meaning making of mental health difficulties in psychological therapy?**

Religion and religious communities have played an important supportive role in people's lives for centuries (Green & Elliott, 2010; Kim-Prieto & Miller, 2018). However, the helpfulness of religion for mental health was increasingly questioned – leading to therapists holding negative biases about religious individuals for much of the 20<sup>th</sup> century (Papaleontiou-Louca, 2021). Over time, this bias has attenuated as contemporary research has shown that religion can have both beneficial and harmful impacts on mental health. Generally, psychological research relating to religion has focused on correlating religiosity and therapeutic outcomes - especially in relation to individuals with diagnoses of schizophrenia. These studies have found little connection between overall religiosity and psychosis treatment outcomes; however, they suggest that stronger religious coping (e.g. prayer) at baseline is associated with better psychotherapeutic treatment outcomes overall (Altun et al., 2018; Mishra et al., 2018; Mohr et al., 2011; Rosmarin, Bigda-Peyton, Kertz, et al., 2013). Similarly, various researchers have found that belief in a benevolent deity (Papaleontiou-Louca, 2021) is associated with better mental health outcomes across diagnostic categories (Rosmarin, Bigda-Peyton, Kertz, et al., 2013; Rosmarin, Bigda-Peyton, Öngur, et al., 2013; Simoni et al., 2002), and across religions such as Islam (Meer & Mir, 2014), Judaism (Huppert & Siev, 2010; Rosmarin et al., 2010), and Christianity (Hall, 2004).

Research suggests that meaning-making may explain the beneficial impact of religion on mental health (Park, 2005), as well as the role religion plays in coping with adversity (Koenig, 2012; Koenig & Pritchett, 1998). Papaleontiou-Louca (2021) found in her review that religion supports coping with mental health difficulties by facilitating positive

emotions and happiness, hope, optimism, meaning / purpose, self-esteem, social support, and social capital. Although the majority of empirical work has found a beneficial relationship between religiosity and mental health, some research has uncovered detrimental impacts. For some individuals, greater religiosity is associated with poorer mental health, and a reduction in religiosity correlates with reduction in mental health difficulties (Sandage & Moe, 2013). This discrepancy was explained by Koenig (2012), who found that belief in punitive and hostile transcendental being(s) was associated with poorer mental health due to the cultivation of fear, guilt, shame, low self-esteem, and social isolation.

It is important to note that all of the research cited here was written in the English language, and that the majority of this work was conducted in contexts characterised by Western, Educated, Industrialised, Rich, and Democratic (WEIRD) participants (Henrich et al., 2010). Therefore, the literature relies heavily on the experiences of individuals from monotheistic and Abrahamic religions such as Judaism, Christianity, and Islam. This work therefore may not represent the experiences of individuals from other world religions.

*In sum*, although some negative impacts of religion on mental health have been found, religion has generally been associated with better mental health, as well as better psychotherapeutic outcomes. The majority of this research has correlated religiosity with mental health and therapy outcomes, as well as correlating religiosity with factors that may explain how it affects mental health (e.g. hope, optimism, self-esteem).

### **What attempts have been made to incorporate religion in psychotherapy?**

The most common integration of religion in psychotherapy is within religiously-adapted therapies, where religion is systematically integrated into a pre-existing therapeutic approach (e.g. Islam-based cognitive-behavioural therapy [CBT]). These include in-session religious interventions such as reference to scripture, teaching of religious concepts, religious imagery, and prayer (Martinez et al., 2007). A systematic review (Lim et al., 2014) and meta-analysis (Smith et al., 2007) have found that religiously-adapted interventions are as effective as non-adapted interventions. Anderson et al. (2015) and Barrera et al. (2012) suggest religiously-adapted interventions may outperform non-adapted therapies. However,

they note methodological shortcomings which prevent strong conclusions from being drawn - such as a lack of Randomised Controlled Trials (RCTs), small samples, and therapist allegiance bias (Anderson et al., 2015). Lim et al. (2014) found in their review that benefits of religiously-adapted therapies were not maintained over time. It remains unclear whether religiously-adapted therapies are effective, and whether they offer benefits greater than secular interventions alone.

Despite the development of treatment manuals for religiously-adapted therapies (Hefti, 2011; Mir et al., 2015; Nielsen et al., 2000), uptake remains low. This can be partially explained by therapist factors (Adams et al., 2015; Brown et al., 2013; Eck, 2007; Lee et al., 2011; Masters, 2010; Plumb, 2011) such as stigma; a lack of knowledge or understanding about religion in general as well as the differences between different religions; discomfort with discussing religion due to personal biases and prejudices; fear of offending the service user; a lack of competence in meaningfully integrating religion into therapy; and ethical considerations relating to the imposition of therapist views on service users and the blurring of professional boundaries. These studies also found facilitators to the incorporation of religion in therapy, such as therapists generally finding it easier to discuss religion in therapy if: the service user broaches the topic first; if religion cannot be separated from the service user's experiences and journey in life; and if the therapist is religious.

In the UK context, there are three main reasons for the implementation gap. Firstly, the majority of research has been conducted in America, and it remains unclear how well these findings generalise to the UK. In America, over 80% of people identify as religious, over 75% of people pray more than once per week, and over 75% of people believe in the absolute existence of God (Martinez et al., 2007). It remains unclear how well these findings may translate to the UK context where although 60.6% of the general population identify as religious, the degree to which individuals participate in religious activities varies greatly (ONS, 2018). Secondly, there is a lack of funding to demonstrate the effectiveness of religiously-adapted therapies, making it harder for them to be included in NICE guidelines, and hence provided through the NHS (DeBrun, 2013). Finally, therapist barriers mean that

religion is not included in secular therapies, even where there would be scope to do so. There is a tendency for therapists - especially clinical and counselling psychologists - to identify as atheistic, as shown by Walker et al. (2004) in a survey of 3813 therapists. They found that religious therapists were less likely to be actively involved in religious activities and communities than service users who were religious. A qualitative study with 16 experienced psychologists (Magaldi-Dopman et al., 2011) found that atheist therapists experienced negative emotions (self-consciousness, defensiveness, confusion) in relation to religion, and were more apprehensive in discussing religion with service users.

There has been a recent surge in interest about meaningfully incorporating conversations about diversity in psychotherapy - especially following the murder of George Floyd and the subsequent global uptake of the Black Lives Matter movement, and the stark racial inequalities highlighted by the coronavirus pandemic (Weine et al., 2020; Yancy, 2020). Religion is central to many people's lives, is a protected characteristic under the Government Equalities Office (GEO) 2010 Equality Act (GEO, 2015), and is included as a key area of identity and lived experience within the social GRRRAACCCEESSS model (Burnham, 2012). It is important to note that conversations about the importance of acknowledging and discussing diversity in therapy predate the events of 2020; however, increased interest does not mean increased incorporation of religion in therapy. Masters (2010) suggests that whilst stigma within the field of psychology in relation to religion is reducing over time, this has not yet translated into genuine incorporation of religion into training programmes, research, and clinical practice. Masters notes that clinical psychology as a profession needs to acknowledge and overcome biases in order to achieve truly helpful integration of religion with therapy.

It is important to also note the influence that religion has had on psychotherapy over time. For example, practices from Buddhism have been integrated into CBT paradigms such as mindfulness-based cognitive therapy (Crane, 2008) and acceptance and commitment therapy (Hayes et al., 2009). However, these approaches focus largely on the experiential process of meditation (as a form of metacognitive awareness and control) without the

ontological or philosophical framework (e.g. of Buddhism). This serves to religion away from practices in order to make them more acceptable to secular audiences – hence strengthening secularism in clinical psychology (Marx, 2015).

*In sum*, evidence for religiously-adapted therapies is mixed, and uptake has remained low - especially within UK NHS contexts. Given this, it is important to consider how religion can be meaningfully discussed in therapeutic contexts whilst accounting for systemic (funding, NICE guidance) and therapist factors (stigma, bias).

### **What are the gaps in the literature?**

The majority of empirical research in this field has focused either on correlating religiosity with mental health and therapy outcomes, or on the views of clinicians with regard to incorporating religion into therapy. There is an obvious gap here: the voices of religious service users are not being heard. Accordingly, this doctoral project focused on speaking directly with religious mental healthcare service users to understand how they made sense of their experiences of mental health difficulties in the context of their faith, and how they experienced explorations of this in their individual therapy. Meaning-making was a large focus of this research, as well as service users' perceptions of the factors which act as facilitators and as barriers to the incorporation of religion in therapy. It was hoped that by exploring service users' perspectives, a deeper understanding of religion, mental health, and therapy could be developed - with a view to informing future psychotherapeutic practice.

The next section of this CI provides a theoretical framework for understanding meaning-making processes, and relates this to religion and the experience of mental health difficulties. This theoretical background will inform how data from the interviews will be conceptualised and analysed in Part 2 of the thesis.

*In sum*, whilst there is a corpus of evidence demonstrating the benefits of religion for mental health and therapy, most of it has been correlational or focused on the views of therapists. This has resulted in chronic underrepresentation of the voices of religious service users, whose views on the incorporation of religion in therapy must be taken into account to inform future clinical practice. To do so, one must first examine the psychological processes

which underpin the beneficial impact of religion on mental health, and how this relates to the psychotherapeutic process.

## **Section 2: How can one conceptualise meaning-making, religion, and mental health difficulties in relation to psychological therapy?**

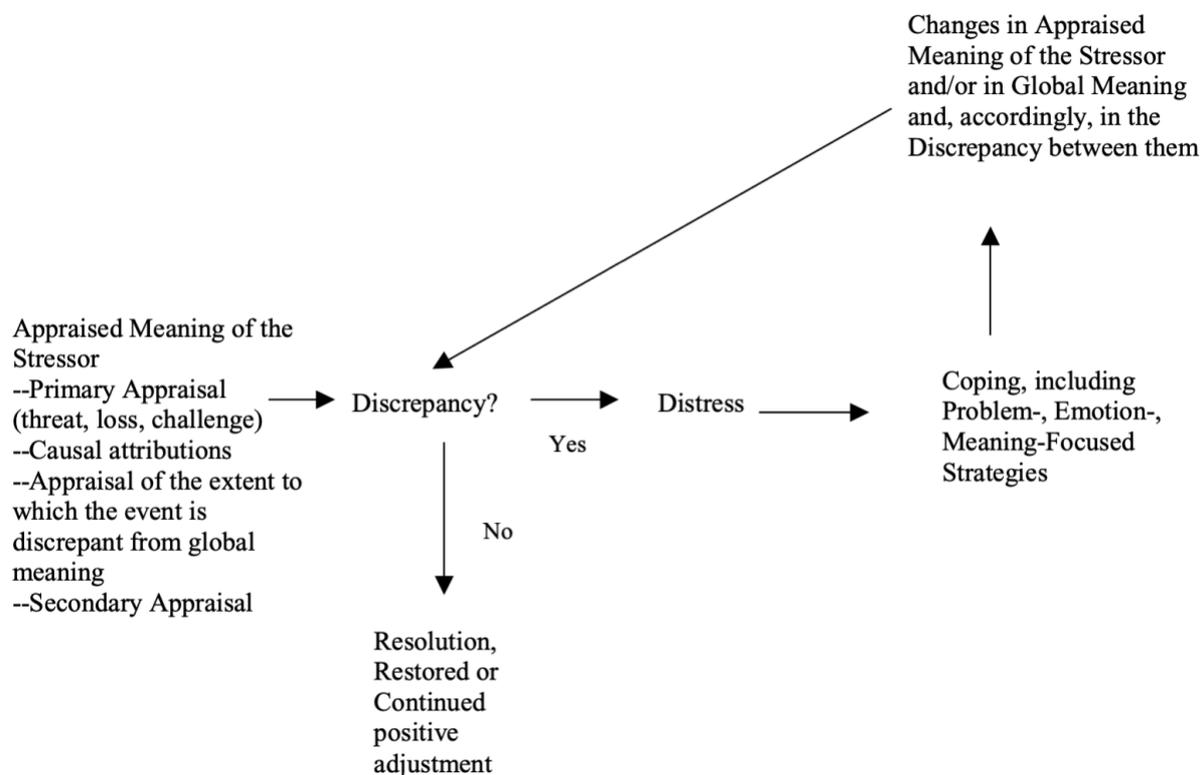
### **Meaning-Making and Coping**

All humans experience difficulties in life; the ways in which people makes sense of those difficulties and cope with them determines the nature and quality of their realities (Green et al., 2010). Meaning-making processes have been identified as more effective than emotion- or problem-focused coping in the context of chronic and/or uncontrollable stressors such as bereavement, cancer, and mental health difficulties, due to there being no specific problem to be “solved” in these instances (Lepore & Greenberg, 2002). In such cases, changing the appraised meaning of the stressor to bring the appraisal in line with the person’s existing beliefs and goals is posited to support coping and long-term adjustment (Pearlin, 1991). Expanding this theory, Riley and Park (2014) suggest that meaning-making processes are dependent on the controllability, threat, centrality, and challenge posed by the stressor.

Park and Folkman (1997) developed the Meaning-Making Coping Model (MMCM) to explain the psychological processes which underpin understanding and coping with stressors which cannot be problem-solved (Figure 1).

### **Figure 1**

*Meaning-making Coping Model, Park (2005)*



As Figure 1 depicts, the MMCM is based on two key processes: global meaning and appraised meaning of the stressor. Global meaning refers to global beliefs (schemas relating to the nature of the world) and global goals (values and motivations). Appraised meaning refers to primary appraisals of the stressor (e.g. threat, loss), causal attributions about why the stressor has occurred (e.g. coincidence, bad luck), appraising the discrepancy between global system of meaning and the stressor, and decisions relating to coping strategies (secondary appraisal). When a stressor is encountered, the individual makes sense of the stressor, and assesses the degree to which this appraisal aligns with their pre-existing beliefs about the nature of the world. If there is no discrepancy between appraised meaning and global meaning, the individual is able to positively adjust in order to reach a state of resolution. If the appraised meaning is sufficiently discrepant from the global meaning, distress is experienced; the extent of discrepancy between the appraised meaning and global beliefs determines the degree of distress. This distress can lead to feelings of loss of control, unpredictability, and incomprehensibility. Managing the distress involves adjusting

the appraised meaning, adjusting global meaning, or both - through a dynamic process that evolves over time.

*In sum*, meaning-making processes are especially important during times of hardship. The Meaning-Making Coping Model provides a helpful formulation of the pre-existing beliefs and goals (global meanings) that influence - and are in turn influenced by - situational meaning-making processes (appraised meaning). This model helps us to understand why an individual may experience distress when confronted with a stressor, and why the same stressor can have vastly different impacts on different people.

### **Meaning-Making and Coping in the Context of Religion**

Religion can be defined as “a system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed towards such a power” (Argyle & Beit-Hallahmi, 2013, p. 1) and is often used to understand and cope with existential problems such as the meaning of life, death, suffering, and injustice (Pargament, 1997). Religion is also associated with coping strategies such as prayer, forgiveness, and seeking support (Pargament et al., 2000). Integrating this into the meaning-making coping model, Park (2005) posits that religious meaning-making can inform both global and situational meanings - especially in the context of chronic and uncontrollable stressors such as trauma and loss.

In relation to appraised meaning, it has been found that religion is often used to make causal attributions about stressors (Spilka et al., 1997), and that the specific appraisal of the stressor is dependent on the individual’s global religious beliefs (Furnham & Brown, 1992). Global meanings in relation to religion may include beliefs such as: God only determines that which I can handle, God is communicating something important to me, and this is a punishment from God (Furnham & Brown, 1992). When appraised and global meanings are in conflict, reappraisal is required; as religious beliefs are fairly stable and consistent over time, it is more likely that people revise their situational appraisals than their religious beliefs (Pargament, 1997). For example, belief in a benevolent God presupposes a situational appraisal that “I am being punished for my sins” - therefore, this may be reappraised as “God only gives me tests that I can handle”, hence reducing the discrepancy

between situational and global appraisals, resulting in reduced distress. This process of reappraisal is a form of coping, and has been associated with better outcomes for wellbeing in the long-term (Park, 2005).

Sometimes the discrepancy created by the stressor is too great to reconcile with pre-existing global beliefs. Overcoming this involves changing global beliefs and goals e.g. viewing God as less powerful, no longer believing in God, believing oneself as sinful, believing the devil to be more powerful than God (Pargament, 1997). For some people, this may lead to a reduction in faith, whereas for others faith may be strengthened (Emmons et al., 1998).

***In sum***, the presence of strong religious faith may, on the one hand, increase distress due to greater discrepancies between global beliefs and situational appraisals. On the other hand, religious faith may have a protective influence, facilitating positive reappraisals of the situational stressor thus reducing long-term distress. The meaning-making process, and how that changes dynamically over time, is what determines whether religious coping mechanisms are ultimately helpful or unhelpful for the individual.

## **Religious Meaning-Making of Mental Health Difficulties**

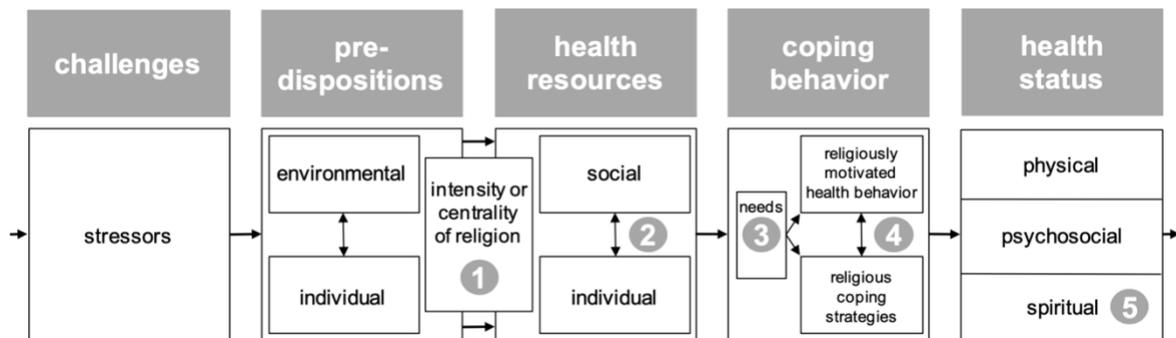
### ***Making Sense of Mental Health Difficulties in the Context of Religion***

Whilst Park's (2005) MMCM is helpful for conceptualising the overarching role that religious global meanings play on appraised meanings in response to situational stressors, it does not account for the organising influence of religion on meaning making and coping. Zwingmann et al. (2011) developed the Religious Vulnerability-Stress Model (RVSM), incorporating the role of religiosity in processes that influence the impact of stressors on one's physical, psychosocial, and religious well-being (Figure 3).

The advantage of the RVSM over the MMCM is that it allows us to account for the degree to which religion plays a central role in a person's life, as well as explaining the direct influence of religion on coping behaviours. It also includes religious wellbeing as one of three elements of "health status" alongside physical and psychosocial health - hence building on the definition of mental health given above by Galderisi et al. (2015).

**Figure 3**

*Integrating Religion / Spirituality into the Vulnerability-stress Model, Zwingmann et al. (2011)*



The RVSM posits that health results from a person’s responses to challenges (daily hassles, critical life events, chronic stressors) based on their predispositions, resources, and coping behaviours. Predispositions include socio-cultural contexts (environmental), and hereditary factors (individual). Both social and individual health resources may be related to religion - for example, relying on both religious community (social resource) and specific religious beliefs (individual resource) may improve an individual's coping capacity. Zwingmann et al. (2011) suggest that religious entities (e.g. God, Buddha, angels etc) can also function as social resources at the psychological level due to mental representations of these beings and the comfort that they bring. Coping behaviours provide concrete actions, which may be religiously motivated, to manage the stressor. Religiously motivated health behaviours are preventative measures based on religious ethics, and religious coping strategies are reactive interventions following stressor onset. Predispositions, health resources, and coping behaviours contribute to an individual’s health status - consisting of physical, psychosocial, and spiritual wellbeing. Spiritual wellbeing includes personal, communal, environmental, and transcendental components, and is associated with peace, faith, and meaning.

The centrality of religiosity is integrated into this model to highlight the role which religion plays in an individual’s coping processes; centrality of religiosity is a combination of predisposition and resource, and has substantial impact on overall coping dependent on the

degree to which religion plays a role in an individual's life. Religiosity in this model includes ideology, intellectual enquiry, religious experience, and public and private practice. The more a person has explored and developed these areas of religiosity, the more central religion is in their life.

*In sum*, mental health has historically been defined as the absence of ill-health. More recent definitions have shifted to a positive psychology approach, but remain rooted in fundamentally hedonistic and eudaemonic philosophies. A definition which does not exclude religious individuals, based on altruism, holism, spirituality, and theism is adopted here. Whilst Park's MMCM is helpful for understanding coping in the context of religious faith, it fails to account for the centrality of religion and the mechanisms by which religion influences coping. The RVSM incorporates religiosity into the predispositions, resources, and coping behaviours which influence an individual's overall health - including physical, psychosocial, and spiritual wellbeing.

## **Religious Meaning-Making of Mental Health Difficulties in the Context of Psychotherapy**

### ***Psychotherapy as a Meaning-Making Process***

Psychotherapy can be conceptualised as a social context within which meaning is co-created between therapist and service user (Salvatore et al., 2010). Shifts in service users' meaning-making of their mental health difficulties have been shown to constitute mechanisms of change during psychotherapy, helping individuals to move away from distress and toward a more fulfilling life (Adler et al., 2013). Strong (2003) notes that the therapist and service user each use what is familiar to them - their lived experiences and prior interpretative processes - to make sense of each other in the therapeutic space. Shifts in meaning occur when "we are transported to unthought of places" (Strong, 2003, p. 7) - when the other person, through their subjective interpretative process, helps us to make meanings in a way that would not have been possible alone.

Therefore the therapeutic process is therapeutic precisely because it facilitates shifts in meaning-making through intersubjective dialogue. The centrality of meaning-making to

psychotherapy has been demonstrated across presenting concerns, for example in the contexts of bereavement (Breitbart et al., 2004; Neimeyer & Thompson, 2014; Park & Cohen, 1993; Stroebe & Schut, 2001; Wortmann & Park, 2009), depression (e.g. Holland et al., 2015), and trauma (e.g. Steger & Park, 2012). Meaning-making has also been shown to be a central component of therapy across different modalities, including narrative therapies (e.g. Brown & Augusta-Scott, 2006; Kropf & Tandy, 1998) and CBT (e.g. Marco et al., 2021; . Holland et al., 2015). Additionally, the process of meaning-making in therapy has been evidenced in different populations, such as military veterans (Kopacz et al., 2019), and older adults (Kropf & Tandy, 1998). The rising importance given to meaning-making in psychotherapy is exemplified by the development of a specific therapeutic approach grounded in meaning-making - metacognitive reflection and insight therapy (Lysaker & Klion, 2017).

### ***Religious Meaning-Making in Psychotherapy***

Given that religion can be a significant organising influence on how one understands the world, and that therapy is a meaning-making process, there is a clear place for religious meaning-making in psychotherapy. Although most therapies do not explicitly address meaning-making, this is often the process and outcome of therapeutic intervention (Slattery & Park, 2011). Historically, religious meaning-making has been commonly studied in end-of-life care, where existential therapies and spiritually-oriented interventions are favoured (Breitbart et al., 2004). Interestingly, Knox et al. (2005) noted that there is a greater focus on religion in relation to existential concerns, rather than mental health difficulties - despite both being uncontrollable stressors which cannot necessarily be problem-solved. Consequently, there is a lack of research on the specific processes of religious meaning-making in therapy for ongoing mental health difficulties, and much of the literature infers the ways in which religion influences meaning-making processes within psychotherapeutic contexts (Slattery & Park, 2011). The author conducted a search of electronic databases and hand searched reference lists of papers on religion, meaning making, and psychotherapy. Based on this

process, five studies were identified which explore religious meaning-making in psychotherapy.

Wortmann and Park (2009) conducted a qualitative review of religious meaning-making following bereavement. Although this paper did not focus on psychotherapy specifically, the authors identified various shifts in meaning-making following bereavement including: the loss being assimilated into a religious worldview; religious struggles (and sometimes a loss of faith) following loss; and changes in religious meaning-making during the process of grieving - which may include revision of religious goals, changed appreciation for life, altered view of God, spiritual growth, and a reduction in one's attachment to religion alongside a strengthening of one's faith. Although these findings were not taken from therapeutic contexts, the changes in religious meaning-making are relevant to therapeutic work, where clinicians aim to facilitate shifts in service users' understandings of their experiences to improve their mental health.

Shafranske (2009) and Hathaway and Tan (2009) presented single case studies of therapy modified to meaningfully incorporate religious meaning-making. Hathaway and Tan (2009) explored the incorporation of religion into mindfulness-based CBT (MBCT) whereby religious conflicts (e.g. faith in a benevolent God, in contrast with high levels of self-criticism) were explored in individual therapy. Their intervention invited conversations about the service user's relationship with God, encouraged the service user to connect with God during times of distress, and facilitated the use of scripture as part of cognitive restructuring work. The meaning-making implications of this work were manifold: the service user reported a deepening relationship with God, with increased grace and compassion both from God and toward themselves, and a change in their perception from a punitive God to a benevolent God. This process was associated with improved mental health. Similarly, Shafranske (2009) incorporated religion into psychoanalytic therapy, whereby the service user's religious upbringing, development of their religious identity and values, and internal representations of God were explored. Conversations about the service user's relationship

to their faith enabled a reassessment of current difficulties, reconciliation of past suffering with a religious worldview, and movement towards religious values and goals.

Avants et al. (2005) developed a therapeutic approach specifically designed to target spiritual meaning-making (spiritual self-schema therapy). In service users with histories of substance dependence, 'the addict self' was replaced by 'the spiritual self' through a Buddhism-informed therapeutic process which shifted service users' worldview, identity, and behaviours to reduce the use of high-risk behaviours. Although not explained in detail, the authors noted that service users reported changes in their way of thinking, increased self-love, and experienced freedom from 'the addict self' post-therapy. This suggests a shift in religious meaning-making through therapy which was beneficial to service users' mental health.

Mayers et al. (2007) interviewed religious mental healthcare service users about their faith in the context of therapy. Although their research did not focus explicitly on meaning-making, some participants reported that the process of receiving therapy enabled them to strengthen their relationship with God by putting their experiences into a broader religious context (e.g. God's plan). Other participants noted that through therapy, they came to understand that their struggles were given to them by God to bring them closer to Him - and that finding God in the process of therapy strengthened their belief in His support. Links between religion, meaning-making, and therapy must be inferred - but it is possible to see how therapy may influence meaning-making through the development of novel perspectives and appraisals of one's lived experiences.

***In sum***, empirical evidence suggests that meaning-making is an important element of the therapeutic process across various therapeutic approaches, presenting difficulties, and service user populations. However, there is a lack of research directly exploring religious meaning-making in psychotherapy. Existing evidence suggests that religion can be meaningfully incorporated into non-adapted therapies, and can aid meaning-making through both non-religious therapeutic interventions (e.g. cognitive restructuring, self-schemas), as well as religion-specific conversations (e.g. one's relationship with God, God's plan).

### **Section 3: How Can One Develop an Ontologically and Epistemologically Coherent Methodological Framework?**

Due to the exploratory nature of this research, an Interpretative Phenomenological Approach (IPA; Smith, Flowers, & Larkin, 2009) was chosen to inform the specific methods employed in Part Two of this thesis. IPA is grounded in its own epistemological framework based on phenomenology, hermeneutics, and social constructionism. The vastness of literature pertaining to these orientations cannot be captured in this thesis; the aim is to provide a summary situated firmly within IPA methodology to link these areas of knowledge to our topic of study. Additionally, prior to adopting IPA, some minor adaptations were required due to the topic of study. As this research focuses on the experiences of religious individuals, due consideration is given to the implications of this for the ontological positioning of the research.

#### **Ontology in Clinical Psychology Theory, Research, and Practice**

Ontology refers to the philosophical study of reality (Slevitch, 2011), and is often assumed without being explicitly stated in clinical psychology academia. Presented below is an overview of key ontological considerations for clinical psychology theory, research, and practice as detailed by (Slife & Whoolery, 2006). In relation to this thesis, the following discrepancies are addressed: naturalism vs theism, and realism vs relativism and pluralism.

##### ***Naturalism vs Theism***

The field of psychology has a tendency to view itself as philosophically and theologically neutral due to the reliance of psychological theory, research, and practice on approaches borrowed directly from the natural sciences (Slife & Whoolery, 2006). These approaches are grounded in naturalism which “assumes that God is not required for complete knowledge of the natural and social world” (*ibid*, p. 219) whereas theism posits that transcendental being(s) are *currently active* in the functioning of the world. This fundamental discrepancy between a theistic and atheistic worldview leads to the elimination of the transcendental from psychological research, systematically marginalising and de-valuing this worldview.

In line with naturalism, psychological research focuses on objectivism, empiricism, materialism, and naturalistic reductionism. From the perspective of naturalistic objectivism, any transcendental activity occurs within the subjective mind and hence is not natural or objective - and hence not real. There is an implication that in order to investigate intangible constructs, they need to be operationalised in a way that is tangible and hence falsifiable. This relates to empiricism (only sensory experiences can be known) in psychological research as well as materialism (only that which is tangible and observable can be known), as exemplified by the focus on behavioural outcomes in psychological research. However, most of the concerns of psychology are intangible and nonmaterial - they are operationalised into tangible behavioural outcomes in order to make them observable, but this is not the same as the thing itself. Naturalistic reductionism suggests that “all change is ultimately reducible to, or governed by, unchangeable natural laws and principles” (*ibid*, p. 223), hence a focus on replicability of results to uncover underlying ‘truths’ - a lack of replication is assumed to signify a lack of reality. In relation to religion, the lack of repeatability of religious experiences is interpreted as subjective and non-existent. Replication, reliability, and standardisation in psychology characterise this reductionism - despite the fact that over a century of psychological research has yet to reveal many “natural laws” governing human experience.

Slife and Whoolery (2006) suggest that researchers can mitigate against these naturalistic assumptions by taking a theistically-informed non-reductive interpretive stance - which, notably, aligns closely with the epistemological positions of phenomenology, hermeneutics, and social constructionism discussed below.

In relation to objectivism, the non-reductive interpretive stance posits that biases, values, and knowledges are necessary for true understanding of the world; the “‘objective’ natural world is interpretively known” (*ibid*, p. 222). A non-reductive interpretive approach to materialism suggests a focus on “the entire spectrum of lived experience or meaning... our thoughts, feelings, and even spiritual events” (*ibid*, p. 223), highlighting immaterial and intangible sources of knowledge and understanding. There is an inherent assumption that

lived experiences cannot always be concretised, and that observable behaviours are not directly representative of the phenomena themselves. The focus of the non-reductive interpretive researcher is meaning, and the meaning people make of religious doctrine goes beyond the written words into the “non observed experience of the relations among the printed words (not to mention the interpreter)” (*ibid*, p. 223). A non-reductive interpretive stance to reductionism posits that there is no assumption that knowledge has to be unchangeable or universal across contexts, and to take it further - researchers assume that knowledge is rooted in context and *cannot* be replicated.

Whereas naturalism is the foundation of much scientific research, it is possible to hold a theistic stance whilst conducting empirical work. This involves taking a non-reductive interpretive stance acknowledging that the transcendental plays an active role in the world, and moving away from the limitations of objectivity, materialism, and reductionism.

### ***Realism vs Relativism & Pluralism***

Much scientific enquiry implicitly assumes a realist position whereby phenomena are defined by certain characteristics which exist independently of the perceiver (Miller, 2019). This is a stance which informs diagnostic practices and medical models of “psychopathology” within the field of clinical psychology. In relation to religion, a stance of theistic realism posits that transcendental power(s) exist in the world - aligning with ontological theism. However, when exploring the meaning-making processes of religious individuals, without limiting participants based on their specific religious affiliations, this work cannot hold a strictly realist stance without the risk of invalidating one participant’s worldview in favour of that of another. For example, holding the stance that a Christian God exists and is currently active in the world would invariably invalidate the worldview of participants who are Muslim or Hindu.

Given this, this research must take a partially realist, partially relativist, and partially pluralist position in our work: realism in relation to the fundamental existence of transcendental phenomena regardless of religious affiliation; relativism (Baghramian & Carter, 2020) in the understanding that there is no single ‘objective’ reality; pluralism

(Russell, 2019) in relation to the existence of multiple equally valid worldviews (i.e. different religious beliefs). Doing so allows us to base our understanding of the data in a theistic framework without limiting this to one specific religious affiliation.

***In sum***, this thesis rejects the naturalistic stance taken by the majority of psychological research, favouring instead a theistic ontological position. It is necessary not to invalidate the experiences of individuals from different religions, and to take a partial position in relation to realism, relativism, and pluralism whereby transcendental powers are currently active in the world (theistic realism) *and* there are multiple equally valid (pluralism) and equally true (relativism) worldviews.

### **Epistemology**

Epistemology (Setup & Neta, 2020) is concerned with the nature of knowledge and the process of knowing, and relates to the question 'How do we know what we do about reality?' (Slevitch, 2011). When developing a qualitative study in which individual interviews will be conducted, it is important to consider how holding a theistic non-reductionist ontological stance influences the process of knowing - primarily in relation to the nature of human experience (phenomenology), the process by which individuals make meaning of their experiences (hermeneutics), and the impact of the researcher in this meaning-making process (social constructionism). The below section draws heavily on the epistemological underpinnings of IPA as set out by Smith et al. (2009).

### **Phenomenology**

Given that this thesis focuses on understanding people's lived experiences of mental health difficulties and their religious faith, one needs to consider the role of phenomenology. Beyer (2020) describes how Husserl studied consciousness and human experience - with the explicit understanding that these experiences are bound by their socio-cultural contexts and arise from idiosyncratic viewpoints (Smith, 2018; Wynn, 2016).

Toadvine (2019) summarises the work of Merleau-Ponty, a phenomenologist who highlighted the centrality of the embodied nature of our experiences, and the ways in which this leads to the privileging of our own idiosyncratic positioning on our experiences of the

world and the meanings people make. Merleau-Ponty emphasised the fact that two people can never share the exact same experience due to this inherent entrenchment of each person's experiences within their own position - one can never fully know the lived *embodied* experience of the other (Smith et al., 2009).

Based on IPA and in relation to this thesis, phenomenology highlights that individuals' lived experiences of religious faith and mental health difficulties are influenced by the socio-cultural contexts of their lives, and cannot be known by the researcher in their purest embodied form.

### ***Hermeneutics***

As described by Smith et al. (2009) and Wheeler (2020), Heidegger developed Husserl's work, noting that in accessing another person's lived experience, one must take an interpretative stance - and in doing so add a layer of subjectivity. The process of making sense of one's own experiences is known as hermeneutics (Mantzavinos, 2020), and in the context of an interview between two people, a double hermeneutic process unfolds (Smith & Shinebourne, 2012). Double hermeneutics refers to the process by which the participant makes sense of their experiences, as the researcher simultaneously attempts to make sense of the participant's process of meaning-making.

In relation to this thesis, hermeneutics highlight the interpretive process unfolding during interviews, in which participants attempt to make sense of their lived experiences whilst the researcher simultaneously attempts to make sense of the participant's meaning-making.

### ***Social Constructionism***

In attempting to study the ways in which religious individuals make sense of their experiences of mental health difficulties using IPA, it is necessary to access their lived experience through linguistic account - in this case, a verbal discussion in an interview setting. In doing so, a social context is created within which meaning is created and shared through a process of symbolic interactionism (Smith & Shinebourne, 2012). This falls in line with social constructionism, which posits that power relations in social contexts determine

the ways in which people construct reality, and that meanings arise not in isolation but within a wider social system (Smith & Shinebourne, 2012).

In relation to this thesis, it is understood that the process of the interview - a social context in itself - determines the material that participants share, the way they share it, and the meanings that both they and the researcher make.

*In sum*, the epistemological position taken in this thesis is grounded in IPA which integrates phenomenology, hermeneutics, and social constructionism. This approach suggests that what one can know about reality is socially determined, and the way in which people come to know reality is entrenched in the subjective and interpretative social interactions within which knowledges are created. This epistemological stance aligns with a theistic non-reductionist ontological position; it is possible to believe in the existence of a currently active transcendental power *and* to expect that the socio-cultural contexts of participants' lives as well as the interpretative interactions during the interview will determine the meanings that are made.

## **Methodology**

Given the topic of this research project, it was necessary to incorporate theism into the IPA methodology. This was done by explicitly stating the ontological positioning of the research, and engaging in reflexivity to ensure that the work aligned with a theistic worldview throughout the research process.

## **IPA**

Interpretative Phenomenological Analysis (IPA) is a qualitative methodology developed by Smith et al. (2009) grounded in phenomenology, hermeneutics, and social constructionism. This approach posits that meaning is made in the dynamic process unfolding between researcher and interviewee, and that the ways in which the researcher makes sense of the participant's account of their experiences significantly affects the process and outcomes of the research. IPA is generally used for exploratory research with small sample sizes, and is well-suited to the current study due to the exploratory nature of this work. Due to its epistemology, IPA does not preclude the existence of the

transcendental; therefore, this research used IPA with an explicit theistic stance in Part Two of this thesis. The credibility and trustworthiness of this work was supported through reflexivity (e.g. Mauthner & Doucet, 2003), and through consultation with an Expert by Experience (EbE). This latter point is explored in greater detail in Parts Two and Three of the thesis.

### ***Reflexivity***

Reflexivity refers to a continual process of critical reflection on one's position and how it affects the research process and outcomes (Berger, 2015). The researcher's lived experiences influence what they choose to study and how, how interviewees respond to the researcher and what they share, and the data analysis process including interpretations that the researcher makes (Berger, 2015). Positioning refers to the process by which individuals create and navigate identity within social and discursive contexts (Schwab, 2013).

Positioning is a dynamic process which unfolds during the narration of a story, and refers both to the identity and dominant discourses endorsed by the speaker and the listener.

Exploring and acknowledging these personal and professional positions, a process popular in the post-positivist and post-structural traditions, is perceived as increasing the credibility and trustworthiness of qualitative research (Macbeth, 2001).

As Mauthner and Doucet (2003) highlight, whilst reflexivity is highly regarded in qualitative research, the specific process by which reflexivity ought to be conducted is often missing. One popular method for uncovering biases and assumptions is the bracketing interview (Tufford & Newman, 2012) whereby the researcher explores their prior understandings and expectations of the research prior to beginning data collection. Whilst bracketing is an important and useful tool for reflexivity, it is also necessary to continue this reflexive process during data analysis. This ongoing reflexivity is embedded in IPA (Smith et al., 2009), whereby researchers are encouraged to record their emotional and intellectual responses during interviews and transcript analysis in order to understand how the researcher may be influencing the process and outcomes of the work (Mauthner & Doucet, 2003). Alongside bracketing, this provides a systematic method for maintaining reflexivity

throughout the research process, hence allowing the research methods and findings to be located within the specific positional contexts of the work. This process will be further detailed in Part Two.

**In sum**, IPA is a qualitative methodology used for exploratory research, grounded in phenomenology, hermeneutics, and social constructionism. This method is compatible with a theistic ontological position, and well-suited to the exploration of religious individuals' understandings of mental health difficulties. In order to ensure that the research process aligns with our ontological stance, reflexivity was facilitated by the processes of bracketing and reflexive data analysis. The details of this research process are presented in Part Two.

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## Part 2: Empirical Paper

Exploring Religious Meaning-Making in Individual Psychotherapy

## Abstract

**Aims.** Religion can help individuals to make sense of long-term and complex challenges such as mental health difficulties, but is often not discussed in psychotherapy. This study aimed to explore religious mental healthcare service users' meaning-making of mental health difficulties, and the facilitators and barriers to discussing religion in their long-term individual psychotherapy.

**Method.** Semi-structured interviews were conducted with four Muslim and one Christian participant and analysed using Interpretative Phenomenological Analysis.

**Results.** Participants described a continuum of experience: childhood experiences led to a belief in a punitive God, which negatively impacted mental health and led to disillusionment with religion. Later in life, narratives of a benevolent God led to religion being helpful in understanding and coping with mental health difficulties. In therapy, fear of stigmatisation posed a significant barrier to discussing religion. Some participants went on to consider religion in therapy, finding therapists' openness and non-judgement helpful; these conversations were always initiated and maintained by participants. Other participants experienced their therapists as disbelieving or avoided discussing religion altogether for fear of negative stereotyping.

**Conclusions.** Religious mental healthcare service users want to discuss religion in therapy, however anticipated stigma and experiences of disbelief from therapists pose major barriers. Increasing therapist confidence and competence in discussing religion is likely to support service users' disentangling of religion and culture and facilitate meaning-making of how religion can be both helpful and unhelpful for mental health. As this was an exploratory study with a small sample, it is recommended that future research explores the meaning-making of therapy-naïve participants, individuals with different religious identities, and service users who terminated therapy prematurely.

## Introduction

Religion has been central to the ways in which humankind make sense of the world for millennia, and has historically been associated with healthcare and wellbeing across the world (Koenig, 2012). Individuals who are religious have been shown to have better mental health than those who are not (Peres et al., 2020), and regular religious practice is associated with better physical health, mental health, and social relationships (Schieman et al., 2013; Strawbridge et al., 2001). This beneficial impact of religion on wellbeing has been posited to occur due to religion helping individuals to make sense of their experiences and providing support during difficulty by engendering hope, optimism, purpose, and enabling social support (Papaleontiou-Louca, 2021).

Although religion began to be divorced from healthcare (and especially mental healthcare) in the 20<sup>th</sup> century (Papaleontiou-Louca, 2021) - there has been a resurgence in interest in religion and wellbeing in the global West since the 1990s (Koenig, 2012). Greater religiosity is associated with better quality of life and lower levels of symptoms associated with depression, post-traumatic stress, eating disorders, personality disorders, and schizophrenia (Weber & Pargament, 2014). Furthermore, belief in a benevolent God (Rosmarin, Bigda-Peyton, Kertz, et al., 2013; Rosmarin, Bigda-Peyton, Öngur, et al., 2013; Simoni et al., 2002) and stronger religious coping (e.g. prayer) pre-treatment are associated with better psychotherapeutic treatment outcomes. The beneficial impact of religion for mental health treatment outcomes exists across: Christianity (Hall, 2004), Islam (Meer & Mir, 2014), and Judaism (Huppert & Siev, 2010), as well as multiple diagnostic criteria such as: schizophrenia, substance abuse, depression, anxiety, anti-social behaviours, and bipolar disorder (Papaleontiou-Louca, 2021).

However, there are some studies which have found no relationship between religiosity and mental health outcomes (Mishra et al., 2018), and others which have found detrimental effects of religiosity (Sandage & Moe, 2013). It has been suggested that these discrepancies may arise due to differences in religious meaning-making process (Furnham & Brown, 1992). For instance, some studies have found positive mental health outcomes to

be associated with faith in a benevolent God, and negative outcomes associated with faith in a punitive God (Koenig, 2012). Much research has been conducted on the meaning-making implications of religion (Pargament, 1997; Schwab, 2013; Spilka et al., 1997), culminating in the religious meaning-making coping model (Park, 2005) which provides a framework for understanding how individuals make sense of short-term stressors in the context of their religious faith. More recently, the impact of religion on meaning-making processes for long-term or chronic difficulties (e.g. mental health difficulties) has been conceptualised within the religious vulnerability stress model (Zwingmann et al., 2011). Religion has been found to influence both the meanings made of mental health difficulties, as well as the coping strategies employed (Zwingmann et al., 2011).

There is significant empirical evidence supporting the benefits of religion on mental health and coping in the general population (Koenig, 2012; Koenig & Pritchett, 1998; Papaleontiou-Louca, 2021). Furthermore, research shows that religion has a positive impact on mental health outcomes with clinical populations (Rosmarin, Bigda-Peyton, Kertz, et al., 2013; Rosmarin, Bigda-Peyton, Öngur, et al., 2013; Simoni et al., 2002) – supporting the argument for incorporating religion into psychotherapy (Richards & Bergin, 2005). Given this, religiously-adapted therapies have been developed to systematically integrate religion into pre-existing therapeutic approaches (e.g. Islam-based cognitive behavioural therapy [CBT]). Adaptations include the use of religious imagery, in-session prayer, referencing scripture, and teaching religious concepts in psychotherapy (Martinez et al., 2007; Richards & Bergin, 2005). Religiously-adapted therapies were found to be acceptable for service users, and have equivalent (if not better) outcomes in comparison to non-adapted therapies (Anderson et al., 2015; Barrera et al., 2012; Lim et al., 2014; Smith et al., 2007).

However, despite the existence of manualised religiously-adapted therapies (Hefti, 2011; Mir et al., 2015), uptake within mental healthcare services remains poor. Therapist factors have been suggested to explain this gap (Adams et al., 2015; Brown et al., 2013; Eck, 2007; Plumb, 2011) including: discomfort in discussing religion due to own biases, lack of understanding of religion, lack of competence in meaningfully integrating religion into

therapy, fear of offending service users, and ethical concerns regarding the blurring of therapeutic boundaries. It is important to note that whilst the majority of the general population are religious, therapists (especially clinical and counselling psychologists) are likely to identify as atheists - as shown in a large meta-analysis by Walker et al. (2004). A more recent qualitative study with 16 experienced psychologists showed that atheist therapists were apprehensive about discussing religion with service users, and experienced defensiveness, confusion, and self-consciousness during conversations about religion (Magaldi-Dopman et al., 2011). Masters (2010) suggests that internalised stigma within the field of clinical psychology prevents the inclusion of religion within training, research, and clinical practice.

With recent global events highlighting significant health disparities in the global West experienced by people from diverse cultural, ethnic, and religious backgrounds (Sayyid, 2015; Weine et al., 2020; Yancy, 2020), it is becoming increasingly important to understand how Western psychotherapy can be made more inclusive and meaningful for people with various socio-cultural heritages. This is especially pertinent to the UK context where the majority of mental healthcare is provided by the National Health Service (NHS), with one of the core values being “everyone counts” – pledging to provide equity of care for all members of the population without discrimination or exclusion (GOV.UK, 2012). Given recent interest in improving psychotherapies, it is important to consider religious NHS mental healthcare service users’ experience of therapy in order to inform future clinical practice – especially in light of the most recent census outcomes which show that 60.6% of the UK population identify as religious (ONS, 2018b).

The incorporation of religion into psychotherapy in the UK remains underutilised for three main reasons: therapist barriers such as those listed above reduce the probability of religiously-adapted therapies being offered; the majority of previous research has been conducted in the USA – making it challenging to draw comparisons with the UK population (Martinez et al., 2007); and high-quality empirical studies assessing the effectiveness of religiously-adapted therapies are lacking, meaning that adapted therapies are less likely to

be included in NICE guidelines (DeBrun, 2013) and hence less likely to be offered within the NHS. Additionally, the field of clinical psychology in the global West is grounded in anti-religious ontology and epistemology, which permeates theory and practice, hence further complicating attempts to incorporate religion into therapy (Slife & Whoolery, 2006). For example, most psychological theories are based on principles of realism and positivism which exclude the existence of transcendental forces - hence the very foundations of psychological theory and practice are incompatible with a religious worldview (Slife & Whoolery, 2006).

Although qualitative studies exploring religious service users' perspectives exist, these studies come mainly from physical healthcare contexts such as end-of-life care (Breitbart et al., 2004) and oncology (Ahmadi et al., 2019). Within clinical psychology, research has focused on religious meaning-making in the context of bereavement (Wortmann & Park, 2009) and chronic pain (Wachholtz et al., 2007). Qualitative research on religion and mental health has largely been conducted outside of the UK: in Switzerland, religious coping through a personal connection with God, prayer, and social support were found to help individuals in coping with and improving their mental health (Hefti, 2011). In an American qualitative study, Knox et al. (2005) found that therapist openness and warmth enabled service users to broach topics of religion in therapy, but that feeling judged by the therapist or feeling that the therapist was imposing their own views on the service user prevented them from having helpful discussions about religion in therapy. Service users also reported feeling apprehensive about bringing their religion to therapy, due to fears of being judged negatively by the therapist.

Based on a scoping review and hand-searching of reference lists, only one example of qualitative research on religion and mental health was found to have been conducted in the UK. Mayers et al. (2007) conducted an IPA study interviewing mental healthcare service users in London who identified as either religious or spiritual. They found that participants experienced mixed support for their mental health difficulties within religious communities and felt conflicted about seeking secular help. In therapy, participants were apprehensive to

discuss religion for fear of judgement, but ultimately found therapists to be open and non-judgemental.

It is clear from the extant literature that whilst religion plays a significant role in meaning-making and coping with mental health difficulties, exploration of this in the UK and from NHS service users' perspectives is limited. The current study was developed due to the lack of contemporaneous research on religious mental healthcare service users in the UK, and hoped to extend the work of Mayers et al. (2007). This study aimed to understand how individuals make sense of their mental health difficulties in relation to their religious faith, and to explore the factors which were perceived by service users to be more- or less-helpful in the process of initiating and maintaining conversations about religion in therapy. Due to the exploratory and idiographic nature of this work, an IPA approach was chosen, which centres participants' lived experiences and meaning-making processes.

## **Methods**

### **Study Design**

#### ***Coproduction***

Coproduction refers to a process of sharing power between service providers and service users to improve service provision (Boyle & Harris, 2009). It is often used in qualitative research, especially where the researcher does not share lived experience of the topic or with participants in the study. Given that the trainee was not religious and had not accessed long-term psychotherapy in the NHS, an Expert by Experience (EbE) – WJ-L – was invited to the research team to coproduce this project. Brief information about this project and what would be expected of the EbE who joined the team was shared with the University College London EbE panel. Two EbEs approached the trainee, and WJ-L was invited to join the research team.

She (WJ-L) was consulted throughout the process from research governance to data analysis and dissemination. Coproduction in DClinPsy research is explored further in Part 3 of this thesis.

#### ***Ethics***

This project was approved by the NHS East of Scotland Research Ethics Service (reference: LR/20/ES/0069; Appendix 1). Informed consent was obtained from participants. Confidentiality was maintained by assigning pseudonyms to each participant and redacting identifiable information from interview transcripts.

### ***Recruitment***

A purposive sampling method was used; we specifically invited religious service users who had completed long-term therapy to participate in the study. NHS mental healthcare service users in East London were recruited (see Appendix 2 for recruitment materials), where the majority of the population is of non-White ethnicity (ONS, 2018a) and 70.6% of the population identify as religious (ONS, 2018b). Participants were recruited from secondary care psychological therapies services; clinicians identified service users who had been recently discharged from therapy and met eligibility criteria for the study. Clinicians contacted service users to see if they were interested in participating, and shared the contact details of those who consented to the researcher. Service users were eligible if they were: aged 18 or above, had completed at least 20 sessions of individual therapy, self-identified as religious, and were proficient in spoken English. The researcher confirmed this information with clinicians prior to contacting participants, and again with participants prior to beginning the interview.

Whilst the advertised minimum number of completed sessions was 12, we aimed to primarily recruit individuals who had completed a minimum of 20 sessions. Shorter-term therapeutic interventions tend to use disorder-specific models (e.g. the CBT model for panic disorder), focus on symptom-management, or due to time limitations do not consider factors such as religion and culture. Conversely, longer-term interventions increase opportunities for exploring the role of the service user's religious worldview in the development and maintenance of mental health difficulties; therefore, service users who had completed at least 20 sessions of individual therapy were recruited.

As we aimed to understand service users' experiences of discussing religion in therapy, we recruited only those who had completed treatment. Recruiting individuals at the

start or partway through therapy may have limited experiences of discussing religion that they were able to share, and may also have inadvertently influenced the therapeutic process following the research interview. However, as there was no way to know if this influence would be positive or negative, and also no way to conduct a follow-up with participants about the impact of the research interview on their therapeutic experience, it was decided that we would focus only on recruiting discharged service users.

### **Participants**

A total of 5 participants were recruited for this study, in line with IPA recommendations for professional doctorate research (Smith et al., 2009). Demographic characteristics of the sample are presented below:

**Table 1**

#### *Sample Demographics*

<b>Demographics</b>	<b>(N)</b>
Age	27 - 36
Ethnicity	South Asian (4), African (1)
Religious Identity	Islam (4), Christianity (1)
Gender Identity	Female (3), Male (2)
CRS-15 Scores	2.6 - 4.9

### **Participant Interviews**

Data were collected by NA (author) through one-to-one 90-minute interviews which were conducted remotely and audio recorded using Microsoft Teams due to covid-19 restrictions.

Each interview began with an explanation of the rationale for the study and gathering of sociodemographic data to characterise the sample. The first part of the interview consisted of administering the 15-item version of the Centrality of Religiosity Scale (CRS-15; see Appendix 3). The CRS is a measure of the strength of religious faith which has been used in over 100 studies with more than 100,000 participants across 25 countries, and has been shown to be reliable and valid across cultural contexts, religions, and over time (Huber & Huber, 2012). Overall scores on the CRS-15 range from 1 to 5, with a score of 1 denoting

low / no religiosity, and a score of 5 denoting significant centrality and salience of religion in a person's life.

The main part of the interview used a semi-structured interview schedule as a guide. The semi-structured interview schedule was developed by NA in consultation with WJ-L (EbE) and two research supervisors (henceforth referred to as 'the research team'). This was refined through a pilot interview with another EbE who was religious (CRS-15 score: 3.9) and had accessed long-term psychotherapy in the NHS.

**Figure 1**

*Semi-structured Interview Schedule*

<b>Interview Questions</b>
Tell me about what your religion means for you.
What role does your religion play during times of difficulty? When you're experiencing mental health difficulties?
Did you speak with your therapist about religion? What were those conversations like?
What helped you to discuss religion with your therapist?
What got in the way of having those conversations about religion?
<b>Additional Prompts</b>
What did that mean for you? Who brought the topic of religion to therapy? Was there anything your therapist did which helped / got in the way of these conversations?

**Data analysis**

Interviews were automatically transcribed by the free Microsoft Stream service, and later manually transcribed, edited for readability, and redacted for personal identifying information by NA.

Transcripts were analysed using IPA. NA completed each stage of analysis independently and consulted with the research team prior to progressing to the next stage. A four-stage analysis process (Table 2) was used as described by Smith et al. (2009); see Appendix 4 for examples of each stage of this process. NA kept a reflective journal throughout this process, and used their reflections to inform coding and analysis. The four-stage process below was used iteratively; following each stage, NA revisited the previous

stage and transcripts to develop greater depth of analysis. This led to a continual restructuring of tables of themes and expansion of relevant quotes selected from each participant's transcript.

**Table 2**

*IPA Data Analysis Process*

<b>Stage</b>	<b>Description</b>
1: Familiarisation	Reading and re-reading interview transcripts.
2: Initial notes	Reviewing each transcript line-by-line to make initial notes based on content, language, and meaning.
3: Emergent themes	Developing a table of emergent themes for each participant's transcript.
4: Cross-dataset analysis	Comparing tables of emergent themes across participants to explore convergence and divergence within the dataset.

**Stage 1**

In this stage, each interview was transcribed and read multiple times to help NA become familiar with the data.

**Stage 2**

Each participant's data was analysed in turn, and cross-participant comparisons were not made until Stage 4 of the analysis. In Stage 2, NA read each transcript line-by-line and added notes relating to content (descriptive codes), linguistic features (language codes), and underlying meanings (conceptual codes). Stage 2 aims to reduce the amount of data and begin the interpretative process (conceptual codes) whilst maintaining the depth (linguistic codes) and breadth (descriptive codes) of analysis.

**Stage 3**

Initial notes were reviewed to generate emergent themes. This stage aims to reduce the volume of data and to foreground IPA's focus on meaning-making without becoming too far removed from participants' words. Emergent themes focus on participants' ways of understanding their experiences, as well as how the researcher makes sense of this. In this stage, links are made within specific passages of the transcript as well as across the

transcript as a whole to develop both convergent and divergent themes. Emergent themes for each participant were written on pieces of paper and spread on a table. They were organised by NA to collapse certain themes or expand others in a way that created a narrative of the participant's experiences. Following this, a table was created to link emergent themes with specific quotes.

#### ***Stage 4***

In this stage, the tables of emergent themes from each participant are compared to develop points of convergence and divergence in the dataset. This was accomplished by writing all the emergent themes on pieces of paper and arranging them on a table. Themes were again collapsed or expanded upon based on the entire dataset. Following this, a cross-dataset table of themes and quotes was created.

#### **Reflexivity & Epistemology**

All IPA research must have an explicit focus epistemology as this is a cornerstone of the methodology. Additionally, IPA requires researchers to engage in reflexive processes to examine their influence on the work. Presented below is a summary of our epistemology and attempts to embed reflexivity throughout the research process.

#### ***Ontology & Epistemology***

Most clinical psychology theory, research, and practice stems from an ontological position of naturalism which excludes the existence of God (Slife & Whoolery, 2006). Given the focus on the experiences of religious service users, this research took an ontological position of theism which acknowledges the existence and active influence of transcendental power(s) in the world (Slife & Whoolery, 2006).

Epistemology refers to the ways by which one can gain understanding of the world, and is a central tenet of IPA. In line with Smith et al. (2009), this work is grounded in phenomenology, hermeneutics, and social constructionism. It is recognised that psychological phenomena (such as meaning-making) are highly idiosyncratic and arise from individuals' lived experiences and worldviews - hence are inherently subjective (Smith, 2018). Additionally, in attempting to gain an understanding of those experiences in

participants, the researcher enters into a double hermeneutic process (Smith & Shinebourne, 2012) whereby: the participant attempts to make sense of their experiences - whilst the researcher simultaneously attempts to make sense of the participant's experiences. This adds a layer of subjectivity and interpretation to the analysis. Given that the research interview is a social context, the meanings made are unique to the people present and the language used to co-construct understandings – hence aligning with social constructionism.

### ***Positioning & Reflexivity***

NA comes from an Indian Hindu cultural and religious background but does not consider herself to be religious. NA has accessed medium-term individual psychotherapy, but not through the NHS. Due to the lack of overlap between NA's lived experiences and worldview and the topic / participants under study, WJ-L was invited to co-produce this project. WJ-L comes from an Afro-Caribbean Christian background, and considers herself to be highly religious (CRS-15 score = 5.0). She has also accessed long-term therapeutic intervention in the NHS on multiple occasions. One of the research supervisors is a White woman of Greek heritage of Greek Orthodox Christian faith. She is a clinical psychologist with an interest in Lacanian psychoanalysis. The other research supervisor is a White British man raised within the Roman Catholic tradition who currently identifies as atheistic. He is a clinical psychologist who has accessed four years of twice-weekly psychotherapy and seven years of five-times weekly psychoanalysis.

Prior to participant recruitment, NA and WJ-L conducted a bracketing interview (Tufford & Newman, 2012; see Appendix 5). Bracketing interviews are used to explore individuals' preunderstandings and expectations for the research which may influence different elements of the research process such as the research question, recruitment method, data analysis, and conclusions drawn. Bracketing is often used in qualitative research to guide reflexivity and reduce the impact of biases on the process and outcomes of the research. Bracketing was used alongside an ongoing reflective journal and supervision with the research team to guide the interpretative methodological process.

## Results

Analysis yielded four superordinate and 11 subordinate themes (Table 3).

Participants' relationship with God changed over time, impacting the ways in which they understood suffering and religion. This was framed as a 'personal religious journey' consisting of two superordinate themes: 'God as actively punitive' contained subordinate themes of 'religious upbringing', 'suffering', and 'disillusionment'; and 'God as ultimately benevolent' consisted of 'wellbeing', 'clarity', and 'idiosyncratic religion'. The third and fourth superordinate themes were related to participants' experiences of exploring 'religion in therapy': 'Prior understandings' contained subordinate themes of: 'stigma' and 'expectations for therapy'. 'Experiences in therapy' contained: 'introducing religion', 'facilitators', and 'barriers'.

**Table 3**

*Table of Themes*

<b>Personal Religious Journey</b>	
<b><i>Superordinate Themes</i></b>	<b><i>Subordinate Themes</i></b>
God as Actively Punitive	Religious Upbringing Suffering Disillusionment
God as Ultimately Benevolent	Wellbeing Clarity Idiosyncratic Religion
<b>Religion in Therapy</b>	
<b><i>Superordinate Themes</i></b>	<b><i>Subordinate Themes</i></b>
Prior Understandings	Stigma Expectations for Therapy
Experiences in Therapy	Introducing Religion Facilitators Barriers

All identifying information was removed from transcripts, participants are referred to by pseudonyms and in gender-neutral terms to preserve anonymity, and quotes were edited for readability. Exemplary quotes are presented with each theme; a table of additional

supporting quotes can be found in Appendix 6. Some participants feature more prominently within certain themes than others, reflecting the heterogeneity of the sample.

### **Personal Religious Journey**

Participants were at various points along a continuum of experience in relation to God, suffering, and religion. Participants took a holistic longitudinal perspective, explaining shifts in meaning-making relating to suffering and religion across their lives. Attributing suffering to a punitive God resulted in disillusionment with religion, whereas understanding challenges as ultimately beneficial tests from a benevolent God enabled participants to develop idiosyncratic religious identities. Quotes exemplifying each theme are presented below.

#### **God As Actively Punitive**

Participants' religious upbringings and experiences of suffering were understood as stemming from a punitive God. This was compounded by cultural practices that perpetuated intersectional oppression, leading to disillusionment with religion.

**Religious Upbringing.** All participants spoke of their religious upbringings, focusing mainly on being forced to practice religion:

*In Islam in a way that's kind of the way we've been brought up. As Muslims when we are really little we are told to practice our religion and to say our prayers or else God will punish us and something bad can happen to us. So the way we've been brought up, the things we are told we have this thing, we have this fear in our mind, or at the back of the mind that we must follow our religion. (Noor)*

The use of punitive God narratives to enforce obedience to religion was apparent across participants, and the impact of this was evident in their focus on negative experiences of childhood religion. Only one participant provided a positive example: "*I remember how much of a spiritual high I would get as well from praying.*" (Dilshad);

however, this addictive “*high*” was significantly outweighed by their resentment towards being coerced into practicing religion.

**Suffering.** Although participants resented punitive God narratives, exposure to them in childhood led inadvertently to internalisation of those beliefs, colouring their experiences of suffering. The understanding of challenges such as mental health difficulties as directly resulting from a punitive God was most apparent in Dilshad’s interview:

*Because God was the one who put these men or abusive characters in my life, and at each point was not able to take them away or make it better [...] And so the relationship with God just became another failed male parental depending role [...] it’s easier for me to accept that all the bad things that have happened in my life has happened just because this is all that there is. But if all these bad things have happened and there’s supposed to be an all-loving all-knowing God, then that’s just disappointing. (Dilshad)*

Dilshad identified God as responsible for the abuse and suffering they experienced and questioned the legitimacy of a God who would or could not protect them during times of need. This pain strengthened their understanding of God as punitive, alienating them further from religion.

**Disillusionment.** Attributing suffering to a punitive God led to disillusionment with religion which was heightened by intersectional oppression. Dilshad’s quotes exemplify this, as they were in the midst of this disillusionment at the time of the interview:

*There’s a saying in Islam that God only tests the ones that he loves. So if you’re going through difficulties, it’s actually a good thing because it shows that God is remembering you and he is caring for you [...] there’s only so many times you can kid yourself with that logic. [...] I think it was only after my father passed away [...] And that’s when I sort of started saying to myself well, this is the last straw, but God has*

*consistently not pulled through [...] And this is the biggest thing He could have come through for and He didn't. So I'm sort of done with serving and pleasing and pretending and hoping and waiting. So I'm kind of over it. (Dilshad)*

For Dilshad, the very same religious explanations which had previously brought solace now fuelled their disillusionment with religion. Repeatedly feeling let down by God strengthened their understanding of God as punitive, resulting in them becoming increasingly distant from religion. However, there was a grain of doubt embedded in this; the use of phrases such as “*sort of*” and “*kind of*” suggested that Dilshad was yet unsure of their decision to reject religion. Notably, Dilshad’s CRS-15 score was the lowest of the sample, reflecting their ambivalence towards religion.

***Intersectional Oppression.*** Experiences of intersectional inequality within religious communities further disillusioned participants. All participants were people of colour, three were women, and one participant was gay; four participants spoke explicitly about oppression within religious communities based on their intersectional identities. Notably, these experiences were attributed to religion and not culture:

*I think being a woman and then being an Asian woman and then being a Muslim Asian woman in a community like that, mental health is swept under the rug. Female issues are swept under the rug. In Islam, any issue that doesn't line up with Islam is swept under the rug, definitely. So you can't talk about those sort of things. [...] It just means that there is no space to have that conversation. (Dilshad)*

Dilshad highlighted the ways in which cultural norms, values, and stigmas within religious communities could be silencing. At this point along the continuum of the personal religious journey, participants conflated culture with religion – blaming the religion for cultural practices.

***God As Ultimately Benevolent***

Further in the personal religious journey, meaning-making shifted as participants endorsed narratives of 'God as ultimately benevolent', reconceptualising suffering as part of 'wellbeing' – something necessary for spiritual growth, and achieving 'clarity' about the distinctions between religion and culture. This converged in the development of an 'idiosyncratic religion' which rejected oppressive cultural practices and focused on a personal relationship with God.

**Wellbeing.** There was a clear shift in how participants made sense of suffering across the religious journey; whereas Dilshad blamed a punitive God for their traumatic experiences, others understood suffering as part of a necessary process to strengthen their wellbeing and faith.

*Sometimes in the Western society you get so busy with life you sometimes forget some of these important factors that matter to you. Like praying and connecting with your faith and things like that. So these difficulties in life sometimes remind you to reconnect with your faith [...] these turmoils and tribulations that we go through in life are given to us to challenge, to build on our characteristics and build on our faith. And I guess it's a form of calming mechanism when you're going through difficulties because later, you remember God will never put you in a position that he knows you can't handle. (Faridi)*

Faridi's benevolent attributions to suffering completely changed the meaning of suffering and engendered hope. However, the use of the words "sometimes" and "I guess" suggested an element of doubt, which was mirrored in a CRS-15 score only 0.6 higher than that of Dilshad. For Noor, rejecting punitive God narratives enabled them to consolidate their faith, especially in the context of their mental health difficulties:

*I feel that I've experienced many problems in the past and because of the way I grew up, I've got mental health issues. So I feel that my life was on the rocks and I could*

*have either gone mad or died. But I feel my God was there to protect me and He protected me [...] after my own personal experiences that I went through, my belief became stronger that there is one God, God exists and we must thank him. (Noor)*

Noor and others endorsed a biopsychosocial causal model of mental health, attributing the development of their difficulties to childhood experiences of inequality and abuse. Having God's support during those darkest moments – noting the subtle equivalence of 'madness' and death – strengthened Noor's faith and enabled coping. This was reflected in Noor's CRS-15 score, the second-highest in the sample.

**Clarity.** Participants with an understanding of God as ultimately benevolent were better able to disentangle the differential impact of religion and culture on their mental health.

*I guess that there is a generation divide of how faith is associated with mental health [...] If my mum was here with me right now, we were having a joint discussion with you and you ask that question 'why do you think your daughter went through what she went through?' Her response would be 'it's because she's not religious. She doesn't pray she doesn't cover herself and that's why she's going through these difficulties'. But to me, that's not an answer [...] because my mother she's failing to acknowledge my mental health because she sees it as a punishment [...] a lot of older generations get confused between culture and religion. (Faridi)*

Faridi distinguished cultural explanations of mental health difficulties as a punishment, from their own understandings based on a biopsychosocial model – allowing them to engage with religion whilst rejecting cultural practices. This was echoed by Noor and Ariel.

**Idiosyncratic Religion.** Participants were at different points along the continuum of the personal religious journey. Rubaiyat continued to struggle to disentangle culture and

religion, being told "Therapy is deviating from religion... it's gonna make you not religious" threatened the legitimacy of their newly-forming idiosyncratic religion:

*I struggle with mental health - at home it's difficult to talk about, like 'it's a taboo, don't talk about that, it's a problem, it's bad' [...] And that's something I battle with every day that I'm trying to engage in my religion, but I hate it [...] in terms of how I'm expected to dress and wear a hijab, and be covered. I don't really engage in that, so they (family) don't see me as religious. But actually in my everyday life I actually do do religious stuff [...] I'm trying to use both of them (religious and secular practices), I intend to use both of them in the future. But again it's really difficult because I go back and forth. (Rubaiyat)*

Whilst Rubaiyat's conflict seemed similar to that of Dilshad, Rubaiyat was taking active steps to reconnect with their religion and to integrate secular (e.g. yoga, mindfulness) and spiritual (e.g. prayer, fasting) practices. This was reflected in Rubaiyat's CRS-15 score which was 0.6 higher than that of Dilshad. This conflict about the validity of idiosyncratic religion was described by Noor:

*Although I consider myself Muslim and I feel proud to be a Muslim, I am not really a practicing Muslim [...] Well, some things about my religion make me feel bad, I don't at all believe in all those things about homosexuality being illegal in Islam or homosexuality being punishable by death or whatever [...] Killing one person is killing the whole humanity [...] I know religion can be important, but we must make our own decisions. It's not that we have to follow religion blindly. (Noor)*

Noor's distinction between their Muslimness and being a "practicing Muslim" raised questions such as: what does it mean to be a Muslim? What is permissible and legitimate in religion? How far can one deviate from this to still be considered religious? Noor's focus on

agency and choice in religion was echoed by Faridi: " *I'm not gonna let someone emotionally blackmail me into having this faith. I choose to have this faith*". The contrast with coercive religious upbringings was striking: a reclamation of faith. For Ariel, developing an idiosyncratic religion involved rejecting hypocritical cultural practices and welcoming God into their life:

*To me it just felt wrong. I can't be hallelujah Sunday, cursing Monday to Saturday [...] when you don't have God, you forever have a thirst, you forever have a void in your life [...] all I know is I prayed to God. And my brain was locked to something, and once I prayed, it is now unlocked. (Ariel)*

Ariel contrasted their childhood religious experiences with their current relationship with God; prayer revealed a new understanding of the world. Ariel's language suggested that belief in God was equivalent to "thirst" and hunger, fundamental to their existence – as reflected in Ariel's CRS-15 score, the highest in the sample.

### **Religion in Therapy**

Participants described prior understandings of therapy, including stigma and expectations of what would be discussed. Despite fears of judgement, four out of five participants went on to speak about religion in therapy. They described their experiences of introducing the topic of religion, and facilitators and barriers to discussing religion in therapy. Quotes exemplifying each theme are presented below.

#### ***Prior Understandings***

All participants spoke of religious stigma in society and fears of being judged by their therapists. Additionally, participants had certain expectations of what would be permissible within the therapeutic space. These posed barriers to discussing religion in therapy.

**Stigma.** Although specific questions about stigma were not asked, all participants mentioned experiences of being stigmatised. Faridi's fear of judgement prevented them from discussing religion in therapy altogether:

*Because religion is unfortunately it's been seen as a subjective type of thing. So I try not to bring a conversation in where somebody may not understand from my perspective [...] Now if they ask me a question that was associated with my religion, then to me that would be OK. That's something they brought it onto the table - that's something I can discuss [...] I don't want that to cloud the main point of what the therapy is about [...] I mean, the only reason why I wouldn't want them to only identify me as a Muslim is because of the current situation where Islam is portrayed to be a very dangerous faith, a negative faith. And I wouldn't want someone who hasn't got to know me first as an individual and only associate me with my religion to make that assumption that I could be a negative person that I could be a bad person.*  
(Faridi)

Faridi feared therapists' prejudices 'clouding' – obscuring – their ability to access high quality care without being stereotyped due to Islamophobia. Notably, Faridi felt safer to discuss religion if the other person broached the topic; yet they noted that *"I would still think it's not relevant (to therapy) because my faith to me is personal. It's not something that I openly discuss even in a therapy setting"*.

**Expectations for Therapy.** Stigma and previous therapy experiences shaped participants' expectations. Noor anticipated perfunctory questions about religion during their assessment, but did not expect further inclusion of religion during therapy itself:

*I had thought about it as well, that they will ask me about my religion but not in detail [...] but later in the therapy I wasn't really expecting it. I was like, it will be more about other things.* (Noor)

The expectation that therapy would be about mental health or childhood experiences as opposed to religion specifically was echoed by other participants. Additionally, some

participants felt therapy was unsuited to discussing religion, and did not expect exploration of religion due to the psychotherapeutic modality they accessed:

*I might have gone in like this will fix my identity issue and how I view religion and maybe I'll be able to pray again and maybe God is real and happy and I won't feel scared to follow Islam. And I think that's more of a naivety than a realistic expectation on what you can get from a bunch of CBT sessions. (Dilshad)*

This suggested that participants entered therapy with expectations of what would be permissible within the therapeutic space, and censored themselves regarding religion, which – in conjunction with stigma – made this topic harder to discuss with their therapists.

### ***Experiences in Therapy***

Four participants discussed religion in therapy; they were always the first to broach this topic, and whilst participants found therapists to be open and non-judgemental, there remained a sense of not being believed.

**Introducing Religion.** Religion was introduced unanimously by participants not therapists: to educate, to explain, or by sheer coincidence. For Dilshad, bringing religion into therapy was a way of providing context:

*I only brought it up for context and to provide background understanding [...] The fact that she can't relate on a personal level to being South Asian or being Muslim meant that it would have been a lot of work on my end to lay everything out and explain it. (Dilshad)*

The mismatch in culture and religion between therapist and service user placed the burden of education on the service user, leading to an avoidance of this topic where possible. For others, religion was too central to their day-to-day experiences to omit it in therapy: *"Cause I can't give you any other explanation. I can't give you any other*

*explanation"* (Ariel). Ariel spoke emphatically about having no explanation for their current wellbeing and the positive changes they had experienced in their life other than God. Ariel noted that this was always the answer to their therapist's questions, which was why religion was brought into the conversation repeatedly – they could not answer otherwise. For Rubaiyat, speaking about religion in therapy was a matter of timing: *"it was when it was Ramadan last year. I did talk to my therapist a lot more about that [...] I was watching this series which really changed the way I was thinking."* (Rubaiyat)

Religion was brought to therapy by Rubaiyat because it was foregrounded for them at the time – they were surrounded by religious practices due to Ramadan and were watching an educational video series which significantly impacted their relationship with religion. This suggested that discussing religion in therapy was coincidental – and begged the question ‘would Rubaiyat have discussed religion in therapy if it had not been Ramadan or if they had not watched that video series at the time?’.

**Facilitators.** Therapists were praised by participants for their questioning skills, curiosity, openness, and non-judgement: *"She had good questioning. So knowing what to pick on, knowing what to go back to, and what to piece together"* (Dilshad). For Rubaiyat, it took time to build sufficient trust with their therapist to begin speaking about religion in therapy. When they eventually discussed religion with their therapist, it was coincidental, yet had a beneficial impact:

*I don't think it was the goal, but it was just a by-product of expressing my emotions that led to me learning more about my religion [...] I think it gave me a different perspective on things. Looking at things and how things are similar and how things are different. Or separating religion and mental health in some way.* (Rubaiyat)

Having the opportunity to speak openly and explore one's emotions and experiences in therapy indirectly helped participants make links between religion and mental health. For

Rubaiyat, this enabled further disentangling of culture and religion, supporting their personal religious journey.

**Barriers.** In addition to stigma which influenced expectations for therapy, therapists' responses within therapy were experienced negatively by participants. Ariel had ongoing conversations about religion in therapy due to its significance in their daily life, however, they continued to feel disbelieved and misunderstood by their therapist:

*This whole mental health service, to me, I don't feel that God is in it [...] when I start speaking about religion it felt like I was speaking Swahili to [Therapist] [...] I didn't feel comfortable. I just knew that I got a sense that she was sceptical, and she didn't believe it [...] Cause she wants to hear I jumped around 5 times and I did a little spin on the floor [...] I think possibly that she's probably not religious, because she's asked me this quite a few times. (Ariel)*

The way Ariel likened discussing religion to “*speaking Swahili*” suggested a complete breakdown of communication between service user and therapist. Ariel felt disbelieved by their therapist, and suggested that this stemmed from the therapist's atheism. Ariel hinted that their therapist was seeking something tangible, and was dissatisfied with religious explanations. It is of note that Ariel felt so strongly disbelieved and misunderstood in sessions, and yet religion played such a significant role in their life, that they had no choice but to continue speaking about it in therapy. For Ariel, religion was discussed in therapy but not in a way that facilitated meaning-making.

## **Discussion**

### **Summary of Findings**

This study aimed to explore service users' meaning-making in relation to religion and mental health, and the facilitators and barriers to discussing religion in psychotherapy. Participants' accounts suggested a continuum of experience whereby internalisation of punitive God narratives from religious upbringings led to negative understandings of

suffering, resulting in disillusionment from religion. For participants who shifted to understanding God as benevolent, suffering was conceptualised as necessary for wellbeing, they disentangled religion from culture, and developed idiosyncratic religious identities.

In relation to therapy, participants spoke of the stigma they feared from therapists and how this might impact the therapeutic work. Despite this, most went on to introduce discussions of religion in therapy, and found therapists' openness, non-judgement, and curiosity to be helpful. However, one participant avoided discussing religion in therapy altogether, and another continually broached the topic of religion despite consistently feeling disbelieved by their therapist.

## **Links with Theory and Implications for Clinical Practice**

### ***Personal Religious Journey***

One of the hallmarks of IPA is that the analysis leads to “new and unanticipated territory” (Smith et al., 2009, p. 112); this was exemplified by the ‘personal religious journey’ in our analysis which spanned participants’ accounts but was not directly related to the research questions.

The personal religious journey seen in our sample parallels the ‘stages in faith consciousness’ (Fowler, 1991), whereby individuals have a more concrete understanding of religion in childhood, begin to question their religion in adolescence, and develop an idiosyncratic religious identity in adulthood. According to Fowler (1991), this is characterised by an explicit questioning of one’s commitment to religion, and the development of an identity which transcends cultural and religious roles to fully integrate religion into one’s selfhood. Previous work on religious identity development has focused largely on the general population. The current sample represents a slightly different set of experiences; participants’ intersectional identities (Crenshaw, 2017) – including mental health difficulties, gender, ethnicity, geography, and sexual identity (Burnham, 2012) - heightened their disillusionment with religion as they did not ‘fit’ the socio-cultural norms which their religious upbringings portrayed. Participants spoke of their experiences of feeling ‘othered’ (Canales,

2000) – made to feel excluded and inferior (Brons, 2015) due to their intersectional identities.

Of note, stigma (Dovidio et al., 2000) due to gender, sexual identity, and mental health was experienced from within participants' religious communities. This aligns with prior research showing that mental health stigma within religious communities can impede access to support (Wesselmann & Graziano, 2010) – especially when mental health difficulties intersect with ethnicity and gender (Ciftci et al., 2013). Peteet (2019) recommends that mental health professionals work closely with religious leaders to provide holistic support for service users. This includes exploration of mental health stigma within service users' religious communities, signposting to religious leaders for educational purposes, and openness to discussing service users' negative past experiences of help-seeking.

Sociological research suggests that women from traditionally conservative religions must navigate socio-cultural norms and expectations in order to freely choose their faith and participation in religion (Avishai, 2008). This struggle with religious upbringing and a move towards agency and control was seen in our sample. Relatedly, it has been shown that many gay people move through disillusionment and inner conflicts with religion, and eventually renounce their religiosity entirely (Wagner et al., 1994). As with the women in our sample, the gay participant needed to reconcile their sexual identity with conservative religious narratives in order to develop an idiosyncratic religion. Due to the recruitment method used, participants for whom this process of disillusionment led ultimately to atheism were not interviewed. It would be interesting for future research to explore why disillusionment leads some people towards religion and others away from it.

As our sample was recruited from secondary care adult mental health services, participants had long-standing mental health difficulties – often stemming from significant trauma in early life. Given this, it was unsurprising that many of them experienced severe challenges in reconciling religious narratives of a benevolent God with their lived experiences of abuse and oppression, which seemingly reflected a punitive God.

This is of note as historically, researchers have found that belief in a punitive God is associated with poorer mental health (Koenig, 2012; Papaleontiou-Louca, 2021). In our sample, the opposite relationship was seen: early life traumas which contributed to poorer mental health led to disillusionment and endorsement of punitive God narratives. This raises important questions about the direction of causality of religious beliefs and mental health difficulties.

### ***Meaning-Making***

Religion was sometimes experienced as helpful for mental health and sometimes unhelpful. This varied based on the specific meanings attributed to religion and to suffering, and shifted across the personal religious journey. Participants' conceptualisations spanned their personal histories, providing a longitudinal perspective of shifts in meaning-making and implications for wellbeing over time.

Most notably, the shift from conceptualising God as punitive to God as benevolent, had a transformational impact on participants' experiences and identities. The meaning-making coping model (MMCM; Park, 2005) can be applied to our data. Participants seemed to hold implicit faith in a benevolent God early in life; however, repeated experiences of abuse and injustice created a discrepancy between this global meaning and their appraised meanings of stressors as 'tests'. For Dilshad, this led to a reconfiguration of the global meaning – they began to endorse punitive God narratives and further suffering was attributed to this global meaning. However, for other participants, repeated exposure to trauma led to a change in appraised meanings. For example, Faridi retained faith in a benevolent God, re-calibrating situational appraisals to align with this by focusing on sufferance as an ultimately beneficial test rather than a punishment. Although this shift in meaning-making was evident in the sample, it was unclear what caused the change to occur. Further research exploring service users' explanations for changes in meaning-making and linking this with their personal religious journey may provide useful guidance for clinicians wishing to explore this process in therapy.

The religious vulnerability stress model (RVSM; Zwingmann et al., 2011) can also be applied here. By using the centrality of religiosity scale (CRS-15; Huber & Huber, 2012) our study explored the degree to which religion played a role in participants' lives, and mapped this loosely onto their qualitative experiences of religion, identity, and meaning-making. Quantitative scores from the CRS-15 mapped closely onto participants' qualitative accounts: those who were conflicted about global and appraised religious meanings and felt disillusioned with religion had lower CRS-15 scores than participants who had brought their appraised and global meanings into alignment through the development of an idiosyncratic religion. However, this comparison must be made with caution given our small sample. As the RVSM suggests, spiritual 'health status' – the degree to which an individual was content with their global and situational meaning-making – was seen to impact meaning-making and coping with challenges in our sample. Participants who felt spiritually conflicted responded more negatively to challenges and were less engaged with religious coping behaviours than those who had reconciled those conflicts to develop a religious identity that aligned with their values.

These two models can easily be integrated into clinicians' therapeutic approach (Burnham, 1992) to inform formulation (Johnstone & Dallos, 2013) of service users' presenting concerns and the maintenance of their difficulties. Understanding how discrepancies between global and situational religious meanings may present as identity crises can help clinicians to unpick the factors underlying disillusionment and inner conflict. Supporting service users to explore this may facilitate shifts in meaning-making and enable them to move along the continuum of the personal religious journey.

Relatedly, understanding the centrality of religion in a service user's life can help clinicians to gauge the extent to which conversations about religion may be relevant and useful for therapy. In our sample, participants whose religion was highly central to daily life spontaneously discussed religion in therapy *in spite of* adverse responses from their therapists (e.g. Ariel). It was those participants who felt most conflicted (e.g. Dilshad, Rubaiyat) – who were perhaps in a grey area between fully renouncing and fully reclaiming

their faith – who were most reticent to discuss religion in therapy due both to fears of judgement and their own spiritual struggles. Given that therapy aims to facilitate shifts in meaning-making to resolve such identity crises, formulations incorporating the RVSM may be most relevant to service users who are currently in the process of disillusionment and struggling to develop an idiosyncratic religion.

### ***Religion In Therapy***

It was interesting that participants expected perfunctory and tokenistic questions about their religion during the assessment phase but did not expect this to be explored further during therapy. This linked with participants' understandings of mental health difficulties and their causal models; participants subscribed to a biopsychosocial model (Pilgrim, 2002) which excluded religion, focusing instead on childhood and relational traumas. Furthermore, participants expressed surprise that religion could be integrated into therapy based on the therapeutic modality they had been offered; this suggested that participants had pre-conceptions of what would be 'permissible' or 'relevant' to therapy. This was unanticipated, as it was expected that service users for whom religion plays a significant role to want this to be incorporated into their therapy. However, these outcomes may be a product of the sampling method; all participants had completed long-term psychotherapy (CBT or integrative therapy) provided by White, Western, female therapists within the NHS – so it is possible that they had internalised the biopsychosocial model through therapy. Future research with therapy-naïve participants may help elucidate the meaning-making of mental health difficulties with religious individuals who have not been directly exposed to the Western medical model (Klerman, 1977). Furthermore, one participant highlighted the role of therapist-service user congruence in relation to culture, race, gender, and religion. Although this was not explicitly considered by other participants, it would be important for future research to consider the impact of religious matching between service users and therapists on their discussions relating to religion, and how this is experienced by service users.

Whereas gender, mental health, and sexual identity were sources of discrimination from within religious communities, participants reported a pronounced fear of judgement and

prejudice from outside these communities in relation to religion and ethnicity. Stigmatising narratives (Dovidio et al., 2000) in relation to religion were uppermost in participants' minds and significantly influenced their expectations for and experiences within therapy. These fears link to findings that therapists in Western countries – especially clinical psychologists in the UK – tend largely to be White, female, and atheist (Turpin & Coleman, 2010; Walker et al., 2004). The impact of therapist responses to participants' faith was seen in the interviews as participants either avoided discussing religion altogether, or continually felt disbelieved by their therapist.

Clinicians may mitigate some of this internalised and social stigma in two ways: by actively introducing the topic of religion, and through relational reflexivity (Burnham, 2018). It is harder for an individual who has experienced oppression to broach this with someone who has not - due to fragility and fear of backlash (DiAngelo, 2006) - than for the person who holds more power to do so. When the person with greater systemic power introduces a topic such as religion, they demonstrate that it is a safe space (Rappoport, 1997) to discuss that topic. This was seen in the analysis where Faridi noted that they would only be comfortable discussing religion if the other person broached the topic first. Therapists hold more power (Totton, 2018) in the therapeutic relationship than service users – which may be augmented by social and systemic power (Fitzgerald, 2014) based on the therapist's intersectional identities. Therefore, therapists have more control over which topics are perceived as 'permissible' (Farber & Hall, 2002) within the therapeutic space. All participants in our study who discussed religion in therapy broached this subject themselves, however, one participant who did not discuss religion in therapy did so due to fear of judgement by the therapist. Therapists can leverage their power (Martinez, 2018) to initiate conversations about religion in therapy; communicating to service users that religion is not 'out of bounds', hence disconfirming fears of stigma and judgement.

Relational reflexivity involves therapists examining their own biases and pre-judgements, remaining mindful of their emotional posture towards the service user (Tomm, 1988), and working to maintain neutrality (Tomm, 1987). In doing so, the therapist may

create an open non-judgemental dialogue about religion in a way that is acceptable and useful for service users. Therapist openness, acceptance, non-judgement, and curiosity were identified by our participants as key facilitators for discussions about religion in therapy. It is of note that these are all foundational skills for psychotherapists (Rogers, 1951) and as such do not require specialist knowledge or training. Therapy is a process of exploring service users' experiences and co-constructing meaning (Salvatore et al., 2010), and as with other topics in therapy, it is more important for the clinician to remain curious about meaning-making, rather than focusing on 'truths' (Carone Jr & Barone, 2001; Gonçalves, 1994). However, our participants noted that discussing religion – especially disillusionment and inner conflicts – requires a high level of vulnerability, and that it takes time to feel safe enough to do so. Exploring religion too early in therapy before there is sufficient trust and safety in the therapeutic relationship may be experienced as unhelpful by service users (Horvath, 2000).

Additionally, participants' focus on stigma highlighted the need to educate clinicians about intersectional discrimination such as Islamophobia (Sayyid, 2015), and for therapists to understand the differences between cultural and religious practices. As Loewenthal (2006) explains, clinicians often mistakenly attribute cultural phenomena to religion in psychotherapeutic contexts. This poses a potential challenge for therapists who may not have specific religious or cultural knowledge (Adams et al., 2015) to guide such conversations. It also contradicts the concept of the 'not-knowing stance' which, by some, has been interpreted to mean that clinicians do not need any prior cultural or historical knowledge (Mason, 2018).

Furthermore, not all participants appeared to make clear distinctions between culture and religion in the research interview. The two participants who were processing their disillusionment and inner conflicts appeared to conflate religion and culture in their narratives, which further fuelled the push-and-pull they felt between religion and secularism. Conversely, participants who had developed an idiosyncratic religion clearly demarcated religion and culture, and this distinction was a cornerstone of their current religious identity.

This suggests heterogeneity in religious individuals' conceptualisations of religion and culture (perhaps reflecting their position on the personal religious journey), and hence cautions against making strong inferences about religion or culture in therapy. Therapists are trained to notice subtle shifts in language (Havens, 1988; Russell, 2013); these skills can help clinicians to understand where a service user is positioned on the religious journey, and guide the types of questions used to help service users become more aware of their inner conflicts and processing – as with any other topic in therapy.

### **Strengths and Limitations**

There are only two published qualitative papers exploring religious service users' experiences of psychotherapy: Knox et al. (2005) interviewed 12 American participants from the community, and Mayers et al. (2007) interviewed 10 NHS mental healthcare service users in London. Both research teams were comprised of White psychotherapists, whereas our research team was ethnically and professionally diverse – especially due to the invitation of an Expert by Experience to the team who ensured that the voices of people with lived experience were consistently foregrounded through the research process. An area of improvement in relation to this would have been to invite a Muslim Expert by Experience to the team, as most participants were Muslims. This may have brought a religion-specific lens to the analysis, allowing a more fine-grained analysis focusing on the teachings of Islam.

Both Knox et al. (2005) and Mayers et al. (2007) sampled participants who were mostly White, Christian, women, and on average aged in their forties. Contrastingly, our London NHS sample was comprised entirely of people from racialised communities, four out of five participants were Muslim, three were women, and the average age was 31. These demographics are notable as the majority of clinical psychology research samples western, white, and university-aged (18-22) participants (Henrich et al., 2010; Sue, 1999). The diversity of our sample represented the local population's ethnic and religious composition and enabled typically underrepresented voices to be heard in clinical psychology research. This is especially important in the UK NHS context where there are significant disparities in access, treatment, and outcome for minoritized groups (Williams et al., 2006) – a fact which

directly contradicts the NHS constitutional values of providing equitable care for all (GOV.UK, 2012). Whilst we did not restrict the religious affiliations of participants to any single world religion, most were Muslims which was representative of the local population in London where recruitment was conducted. IPA works well with homogenous samples. All of participants were religious, had experiences of mental health difficulties, and had completed long-term psychotherapy; in this respect the sample was highly homogenous. However, we had four Muslim and one Christian participant, and two women and three men; in these respects, our sample retained some heterogeneity. This degree of similarity and difference within the sample fits well with IPA where the analysis aims to explore both areas of convergence and divergence, as well as possible explanations about why these occur. We suggest that future research could consider recruiting from specific faith groups to explore differences between different religions and meaning-making in relation to mental health.

This study's findings aligned with the outcomes of Knox et al. (2005) and Mayers et al. (2007): participants described secular explanatory models of mental health difficulties, reported challenges in accessing mental health support within religious communities, feared judgement from therapists for discussing religion in therapy, and found therapists to be open and non-judgemental once they had broached the topic of religion in therapy.

This research extends the work of Mayers et al. (2007) who provided a descriptive rather than interpretative analysis – a surprising outcome given their use of IPA, and which may have arisen from their broad scope covering five research questions. The 'personal religious journey' enables differentiation of both specific meanings and changes in meaning-making over time, adding a developmental dimension to existing understandings of religious service users' meaning-making of religion and mental health difficulties. Mayers et al. (2007) did not report the duration of therapy accessed by their participants. Shorter-term therapeutic interventions tend to use disorder-specific models (e.g. the CBT model for panic disorder), and focus on symptom-management, thereby limiting opportunities to explore religion and culture. This study intentionally sampled service users who had completed long-term therapy to increase the possibility of exploring participants' experiences of discussing

religion in therapy. This enabled a fruitful exploration of participants' experiences preceding and during psychotherapy.

The quality of this research was augmented by coproducing with an Expert by Experience to improve credibility (Noble & Smith, 2015), using the Critical Appraisal Skills Programme (CASP) qualitative studies checklist (CASP, 2018), and following IPA-specific guidance (Nizza et al., 2021; Smith, 2011). An exploration of the quality of this study is presented in Chapter 3.

### **Implications for Future Research**

Smith et al. (2009) recommend samples ranging from four to ten for professional doctorate students. They highlight the importance of having smaller sample sizes in order to ensure that there is sufficient depth of analysis per case to ensure a rich and meaningful analysis of the data, and note that the concept of data saturation does not apply to IPA. This study's sample of five falls within the acceptable range for IPA research, balancing depth and breadth of analysis. However, given the small size and exploratory nature of this study, caution is needed in presenting findings as if they were generalisable. Despite this, the overlap in participants' accounts suggests that these themes may have wider applications. These results were developed from a relatively homogenous sample of religious individuals from non-White ethnic backgrounds, who had long-standing mental health difficulties and had completed long-term therapy. These findings may be applicable to other religious NHS mental healthcare service users, especially those with intersectional identities as their experiences may pose specific challenges to religious identity and therapy that may not be shared by others in the general population.

As most of our participants were Muslims, it is recommended that similar research is conducted with individuals from other religions to understand whether there are variations in the personal religious journey. Additionally, the current research focused on the experiences of participants who identified as religious without separating different religions from each other. Whilst world religions vary significantly, the clustering of religions in this thesis was used to highlight the role of social narratives about religion, as well as the impact of power

and oppression on religious individuals who have experiences of mental health difficulties. future research may benefit from larger samples with greater representation from different world religions to explore convergence and divergence in meaning-making.

Furthermore, this study only recruited participants who had completed long-term therapy in the NHS; it would be interesting to hear from individuals who either had not accessed therapy or who had terminated therapy early – especially in relation to the causal models of mental health they may endorse, as well as their experiences of the facilitators and barriers to discussing religion in therapy.

## **Conclusions**

Religious individuals who have long-term experiences of mental health difficulties describe a personal religious journey characterised by shifts in meaning-making. In early life, punitive narratives of God alongside intersectional challenges result in disillusionment with religion. Later in life, understanding God as benevolent helps individuals to reconnect with religion and to forge an idiosyncratic religious identity. In therapy, individuals feel apprehensive to discuss religion due to fear of stigma from therapists. However, once they broach the topic, they find therapists to be open and non-judgemental. Nonetheless, some avoid discussing religion altogether, or continually feel disbelieved by their therapists. Implications for clinical practice include educating and empowering therapists to initiate and maintain conversations about religion through the use of relational reflexivity, and fine attention to service users' language. This study calls for more research on the experiences of religious mental healthcare service users, especially those who have different religious affiliations, have not experienced therapy, or who have prematurely terminated therapy. Improvements to clinicians' provision of equitable and culturally sensitive therapeutic care are likely to significantly impact on service users' experiences of therapy, and their meaning-making of religion and mental health.

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## Part 3: Critical Appraisal

## **Overview**

The aim of this chapter is to critically reflect on the process of conducting the empirical research project with a focus on coproduction and quality in qualitative research. The section on coproduction was developed through discussions with an Expert by Experience and research supervisors, hence is written using “I” / “we” pronouns to reflect the personal and collaborative nature of the work.

## **Coproduction**

### **What Is Coproduction?**

Coproduction is the development of an equal and reciprocal relationship between service providers and service users to create effective changes for both services and communities (Boyle et al., 2010). Within the UK and NHS contexts, conversations about coproduction began with the NHS and Community Care Act (1990), and have been formalised in the NHS Patient and Public Participation Policy (2017). Multiple guidance documents have been published by the National Institute for Health Research (NIHR), outlining the key values and principles of coproduction and systematising the evaluation of coproduction in healthcare research.

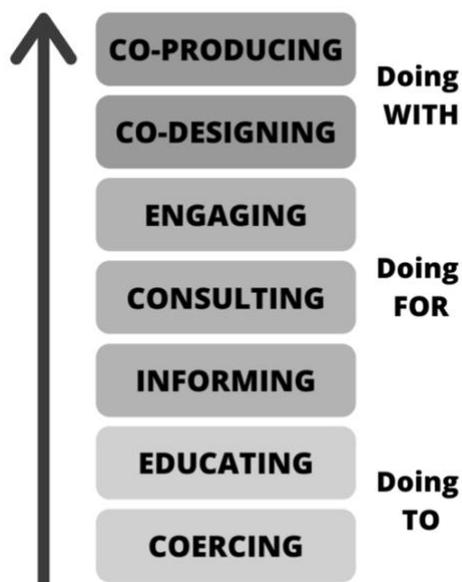
NIHR (2021) outlines five key principles which define coproduction in research: sharing power, including all skills and perspectives, respecting and valuing everyone’s contributions, reciprocity, and building and maintaining relationships. The sharing of power requires that systems and relationships ensure an equal distribution of responsibility, roles, and decision-making. Although certain roles hold greater accountability than others (e.g. the principal investigator holds overall accountability for the project), there is an active sharing of ownership and power across all those involved in relation to key decisions. Including all skills and perspectives requires the research team to invite people who hold knowledges and expertise relevant to the project, and to ensure that the team is inclusive and accessible – especially when working with people from underrepresented groups. Coproducing means respecting and valuing all participants’ contributions equally, and creating safe spaces for diverse perspectives to be shared. There is a need for coproduction to be reciprocally

beneficial for all those involved, including but not limited to financial compensation, training, and personal and professional development. In order to share power in coproduction, building and maintaining relationships is vital. Developing trust in relationships facilitates the sharing of power, valuing and respecting difference, and enables coproduction.

This has led to the development of frameworks such as the ‘Ladder of Coproduction’ (National Coproduction Advisory Group: NCAG, 2021) which helps service providers and users to organise their work:

**Figure 1**

*Ladder of Coproduction, after BusinessLab (2020)*



Distinctions between different rungs of the Ladder are of note, as the use of the term ‘coproduction’ in common parlance does not necessarily reflect its technical definition (Brady & Preston, 2017). The key difference between coproduction and other types of collaboration between service users and providers is the focus in coproduction on equality and power (Slay & Stephens, 2013). True coproduction means that service users’ perspectives are sought, listened to, and enact real change – and that this occurs throughout an entire process or project (NCAG, 2021). When service users are involved in designing services, but are not invited to the whole process, this is ‘co-design’. When service users are consulted but do not hold decision-making power, this is termed ‘consultation’ or

'engagement'. When service users are informed and educated about service providers' decisions, this is called 'educating' or 'informing'. The bottom run of the ladder is 'coercion', where service users are passive recipients, and their perspectives are not taken into account.

### **Why Did We Want To Coproduce?**

Participants in our study were religious, had experienced chronic mental health difficulties, and had accessed long-term therapy. However, the research team did not have much shared lived experience with participants. For example, I (NA) am not religious, have not experienced chronic mental health difficulties, and have not accessed long-term therapy. Given the subjective and interpretative nature of IPA, I wanted to coproduce the research with an expert by experience (EbE) who was religious, had experienced chronic mental health difficulties, and had accessed long-term individual psychotherapy. By doing so, I hoped to foreground participants' voices, and to mitigate against some of the research team's blind-spots (Burch, 2014) and biases. I also wanted to use a coproductive process to increase the credibility (Noble & Smith, 2015) of data analysis by increasing consistency (i.e. the researcher's decisions are transparent) and confirmability (i.e. differentiating the researcher's position from the data).

Credibility can also be improved through respondent validation (Long & Johnson, 2000); typically, participants are invited to review data analysis to improve the acceptability and comprehensibility of study outcomes. I intended to approximate this through coproduction with an EbE who shared lived experience with study participants, but was not a participant themselves. Additionally, I hoped that the coproductive approach would ensure that all elements of the study would be scrutinised from the perspective of an EbE, hence privileging participants' voices throughout the research process, rather than using respondent validation alone, which only allows for critique of data analysis.

### **What Did This Look Like In Practice?**

We formed an initial research team consisting of myself and two supervisors in early 2019, and proceeded to develop a project proposal which was submitted to UCL later that

year. Once the project was approved, we began preparing documentation for ethical approval. It was at this stage that we recruited an EbE through the UCL EbE panel; a brief about the proposed project was circulated to the panel and interested EbEs contacted the team. I met with two EbEs (WJ-L and CB) to discuss the project, hear their ideas, and to administer the CRS-15. This was intended to give both me and EbE a chance to meet each other, and provided an opportunity to understand how we may work together throughout the 1.5 years of the study. WJ-L, was invited to coproduce the research, and CB was later approached for the pilot interview. With the inclusion of WJ-L, we had a complete research team.

The timing of WJ-L joining the team meant that she was not involved in the earlier stages of developing the research questions and methodology; these elements of the proposed project were explained to WJ-L, and she did not raise concerns at this stage. We had to be selective in elements of research governance that we invited WJ-L to review, as she had limited availability and we were working to specific deadlines in order to ensure that we had sufficient time for recruitment, data collection, analysis, and write-up. Therefore, WJ-L was consulted mainly about participant-facing elements of research governance, such as the Participant Recruitment Flyer and the Participant Information Sheet. She provided feedback on language use, colour, and formatting for these documents; changes were made accordingly.

Whilst waiting for ethical approval, WJ-L and I conducted a bracketing interview (Tufford & Newman, 2012) where we interviewed each other about our positioning in relation to the research, and our expectations for the findings. This process allowed us to understand each other better, and built a stronger relationship – which would in due course enable open and honest conversations about the research process and outcomes.

Following this, the research team collaboratively developed the semi-structured interview schedule. This process yielded interesting conversations about what participants may discuss, and how I could sensitively explore different elements of their experiences during the interview. WJ-L supported me to pick up on subtle shifts in language which may

hint at deeper underlying religious meanings by referencing our bracketing interview. She also provided specific prompts to probe for religious meanings, and provided context for themes that may arise in relation to therapy based on her experiences. Although the final interview schedule was reduced to a few fundamental questions, I retained notes from these meetings as supplementary prompts to guide my questioning during interviews.

We received ethical approval in December 2020. However, due to service disruptions over the Winter festive period, we decided to conduct the pilot interview in December, and to postpone recruitment to January. I invited CB from the UCL EbE panel (whom I had met the year before) to participate in the pilot interview. Once I had transcribed this, the research team discussed both my interviewing style and the possible themes that had arisen in the interview. Through discussion with WJ-L, I was able to improve my sensitivity to participants' language during interviews, and to develop my interviewing style to focus more on meaning-making. Although we did not analyse this transcript, it was useful to review the interview as a team and to discuss possible avenues for questioning. This led to further refinement of the semi-structured interview and the supplementary prompts.

The research team reviewed the first draft of the first chapter of the thesis in January 2021. I had a meeting with WJ-L who provided feedback on the inaccessibility of the language I had used, and points where my argument lacked clarity. I used this feedback to simplify my language and added clarifications where necessary. Between January and April 2021, I conducted 5 participant interviews. Unfortunately, WJ-L was not available for much of this time, so conversations about the interviews did not include her. The remaining three of us in the research team reviewed interview transcripts and data analysis. After the thesis write-up was complete, it was sent to all members of the research team to review. WJ-L and I met to discuss her feedback; she highlighted parts of the write-up where I had conflated religion with culture and linked this with research participants' conflation of the two. This helped me to gain perspective on overarching themes in the data, leading to restructuring of the analysis and greater emphasis on the distinctions between religion and culture in the write-up.

The two of us also reviewed our coproduction efforts, and WJ-L provided feedback on how she had found this process. We evaluated our coproduction through an informal conversation as well as using the UK Standards for Public Involvement (NIHR, 2018), a framework which allows research teams to collaboratively evaluate the quality and impact of coproduction in research (see below). Following this, I provided formal feedback to WJ-L to explain how her input had impacted the research and the changes made to my thinking and the research process as a result. I used the Patient and Public Involvement Feedback Form (Mathie et al., 2018) to guide this process.

In coming months, we hope to publish this work and intend that WJ-L will review any journal submissions that are made. We would also like to disseminate findings from this project to the teams we recruited participants from; it is hoped that WJ-L will cofacilitate these meetings in order to share our study's findings collaboratively.

### **Quality and Impact of Coproduction**

There are various frameworks for systematically evaluating the impact and quality of coproductive research. Unfortunately, I was not aware of these approaches until June 2021, which did not leave much time for a thorough assessment. Therefore I met with WJ-L to coproduce a quality and impact assessment using the UK standards for public involvement (NIHR, 2018) for the thesis submission. We intend to develop a comprehensive evaluation strategy following the thesis submission deadline, for example by using the Public involvement impact Assessment Framework (PiiAF; Popay et al., 2014) or the second edition Guidance for Reporting Involvement of Patients and the Public (GRIPP2; Staniszewska et al., 2017). Furthermore, previous researchers have coproduced comprehensive and systematic evaluations of coproductive work, for example by interviewing researchers and EbEs involved in coproduction to explore their experiences of factors which facilitate and challenge coproduction efforts (Hovén et al., 2020). We hope to emulate this, potentially with other trainees and EbEs who had coproduced their DClinPsy projects, in order to inform coproduction in future trainee research.

NIHR (2018) produced a guidance document for assessing the quality of coproduction through six standards: inclusive opportunities, working together, support and learning, communications, impact, and governance. They provide a series of questions relating to each standard to assess whether a project achieved the key values and aims of coproduction. WJ-L and I used this framework as a guide to coproduce an evaluation of our work, as presented in Table 1:

**Table 1**

*NIHR UK Standards for Public Involvement*

<b>Standard &amp; Prompt Questions</b>	<b>Evaluation</b>
<p>Inclusive Opportunities</p> <ul style="list-style-type: none"> <li>• Are people affected by and interested in the research involved from the earliest stages?</li> <li>• Have barriers to involvement, such as payment for time or accessible locations for meetings been identified and addressed?</li> <li>• How is information about opportunities shared, and does it appeal to different communities?</li> <li>• Are there fair and transparent processes for involving the public in research, and do they reflect equality and diversity duties?</li> <li>• Is there choice and flexibility in opportunities offered to the public?</li> </ul>	<p>WJ-L was invited to join our research team relatively early in the process, but not at the earliest stages where key decisions about the research aims, recruitment strategies, and analysis methodologies were being made. Funding was secured for WJ-L prior to her invitation to the team, and all meetings were held virtually due to the covid-19 pandemic. The study was only advertised to EbEs in the UCL EbE panel due to time constraints, which limited the people who could be involved. Some choice and flexibility was offered to WJ-L, but we were limited in this as she was the only EbE on the team and we were constrained by time limitations.</p>
<p>Working Together</p> <ul style="list-style-type: none"> <li>• Has the purpose of public involvement been jointly defined and recorded?</li> <li>• Have the practical requirements and arrangements for working together been addressed?</li> <li>• Have all the potential different ways of working together been explored, and have these plans and activities been developed together?</li> <li>• Is there is a shared understanding of roles, responsibilities and expectations of public involvement?</li> </ul>	<p>The purpose and process of coproduction was decided by me (NA) prior to inviting WJ-L to the team. These ideas were briefly explained to WJ-L but not in detail, and there were no opportunities for her to shape what coproduction would look like in this project. WJ-L's involvement was not systematically recorded or monitored until the final stages of the write-up where existing frameworks were used to retrospectively record her input and impact. Different ways of working were not explicitly discussed, but we have been flexible in responding to challenges as they arose. There was no clear understanding of roles and expectations from the start of the</p>

Standard & Prompt Questions	Evaluation
<ul style="list-style-type: none"> <li>• Have individuals' influence, ideas and contributions' been recognised and addressed?</li> </ul>	<p>project as this was not explicitly discussed. WJ-L's input has been regularly sought and incorporated into the research. However, this has not been fed back to her until the final stage of the write-up.</p>
<p>Support and Learning</p> <ul style="list-style-type: none"> <li>• Is there a range of support to address identified needs?</li> <li>• Have specific resources been designated to support learning and development opportunities for both the public, researchers, and staff?</li> <li>• Do the public know where to go for information and support about public involvement?</li> <li>• Is there a culture of learning by doing, building on and sharing that learning for researchers, staff and the public?</li> </ul>	<p>We did not identify training needs at the start of the project. However, we have invited WJ-L to attend training at UCL on the data analysis method and have shared relevant reading materials to guide data analysis. These actions were not planned in advance, but provided in response to learning needs as they arose. There was no information provided to WJ-L about where she could go for further information and support about this coproduced project. WJ-L felt that the whole project has been a learning process for her, and that there is a culture of learning together. I (NA) would note that we have not shared enough of our learnings within the team, and that we could have supported WJ-L by providing training / reading materials earlier to allow her time to process the information prior to data analysis.</p>
<p>Communications</p> <ul style="list-style-type: none"> <li>• Has a communications plan been developed for involvement activities?</li> <li>• Are the needs of different people being met through inclusive and flexible communication methods?</li> <li>• Are processes in place to offer, gather, act on and share feedback with the public?</li> <li>• Are you sharing your public involvement learning and achievements, good and bad?</li> </ul>	<p>There was no explicit communication plan for this project. We communicated using a range of media such as texting, emails, and video calls – and used these flexibly and interchangeably based on each of our needs and preferences. There were no formal processes for sharing feedback with WJ-L until the final stages of the write-up; these will be incorporated moving forward. We have not yet shared our learnings with others (e.g. UCL, the NHS teams we recruited from) but intend to do so both through publication and through other media (e.g. presenting findings in lectures / team meetings etc).</p>
<p>Impact</p> <ul style="list-style-type: none"> <li>• Are the public involved in deciding what the assessment of impact should focus on, and the approach to take?</li> <li>• Is it clear what information to collect to help assess impact, including who has been involved and how?</li> </ul>	<p>We have used two approaches to assess the impact of coproduction: firstly, WJ-L provided informal feedback on her experience of the process, and secondly we used this NIHR framework to guide an evaluation of our work. The two of us have been involved in this impact assessment. There were no processes in place to reflect on coproduction; we will be incorporating this formally moving forward to provide</p>

Standard & Prompt Questions	Evaluation
<ul style="list-style-type: none"> <li>• Are there processes in place to help reflect on public involvement?</li> <li>• Are the changes, benefits and learning resulting from public involvement acted on?</li> </ul>	<p>systematic feedback to WJ-L and to create opportunities for us to reflect together on what has gone well and what could be improved. The changes and learnings from coproduction have been acted on within the research project itself. We also hope to disseminate this more widely through publication and through continued communication with UCL and the NHS teams we recruited participants from.</p>
<p>Governance</p> <ul style="list-style-type: none"> <li>• Are public voices heard, valued and respected in decision making?</li> <li>• Are public involvement plans in place that are regularly monitored, reviewed and reported on?</li> <li>• Is there visible and accountable responsibility for public involvement throughout the organisation?</li> <li>• Are realistic resources (including money, staff, time) allocated for public involvement?</li> <li>• Is the privacy of personal information protected by collecting and using it in a suitable way?</li> </ul>	<p>We were unable to invite WJ-L's perspective to key decision-making meetings very early in the research process. This meant that WJ-L was not involved in those decisions which shaped the nature and outcomes of our research. We did not have explicit plans to monitor, review, and feedback on coproduction in the project. We hope to do this moving forward. Within UCL there is an EbE panel who have been increasingly involved with many aspects of the DClinPsy course; we hope to feed into this panel and the course more broadly to share our learnings and to encourage coproduction in trainee research. The NHS sites we recruited from do not have designated EbE panels; we hope that by sharing our learnings we can encourage these teams to invest in coproduction in the future. Funding was secured early in the process to ensure that we could reimburse WJ-L for her time and resource. Personal information has been protected suitably, as per our ethical approval criteria.</p>

The values and principles of coproduction outlined by NIHR (2018) and NCAG (2021) overlap significantly. NCAG (2021) describe four key dimensions of coproduction: seeking EbE input, listening to their feedback, enacting change, and doing this throughout a research process. WJ-L felt that her perspective was sought and listened to; it was her first time coproducing a trainee project, and she reported feeling heard throughout the process. WJ-L also noted that this work enacts real change in two ways: firstly, the study itself recognises that EbEs' experiences (lived experience, professional experience etc) constitute expertise – something which is not always acknowledged; secondly, this project hopes to

make coproduction in trainee research more commonplace, which is a form change in itself. WJ-L highlighted that she was unable to be involved in the entire research process due to: the timing of when we invited her to the team (after many decisions had been made), and due to her mental health needs, work commitments, and the unexpected burden of involvement (e.g. the time and resources required to read and process highly inaccessible academic work).

Based on the informal conversations between myself and WJ-L, and our formal evaluation of coproduction presented above, I would conclude that our attempt to coproduce was partially successful but may not meet all the requirements for true coproduction. This was due to multiple factors: firstly, WJ-L was not involved in the entirety of the process – she joined the research team after the research questions and methodology had been selected, hence did not have a say in these key decisions. Secondly, although WJ-L was consulted throughout the remainder of the research process, her input was often sought only for those elements that were deemed to be relevant (e.g. participant-facing documentation, interview schedule) in order to ensure that we were efficient in using her time and resource. Therefore, WJ-L did not have input into all elements of the project. Finally, practical constraints (e.g. deadlines) dictated the pace of work, and the timescales allotted for feedback to be sought and acted upon. Given that the covid-19 pandemic was ongoing throughout this time, and that WJ-L was involved in various other roles outside of this project, it was not always possible to have her detailed input. This resulted in a greater reliance on the rest of the research team (where none of us shared as much lived experience with participants), especially in the later stages of data analysis. At best, this project could be categorised as ‘co-designed’, and at worst, falls within the ‘doing for’ range of collaboration consisting of ‘informing’, ‘consulting’, and ‘engaging’.

We feel that this occurred due to many factors, some of which were outside of our control. As Boyle and Harris (2009) outline, coproduction has become increasingly popular in the UK public sector, yet our systems are not built for this approach. Decision-making is centralised, which makes the re-distribution of power and responsibility more challenging;

this is especially pertinent when the person (e.g. a trainee) trying to champion coproduction does not hold much structural power (Astley & Sachdeva, 1984). Another challenge relates to financial incentives. The funding that we receive for trainee research is limited, meaning that we cannot offer competitive hourly rates for EbEs' time. This poses important ethical questions for us as researchers about the ways in which we value the time and emotional labour (James, 1989; Mann, 1997) of EbEs. It also makes coproduction less appealing for interested EbEs who often have many demands on their time and resource – and hence may not be able to commit to a low-paid role in research. This perpetuates oppressive practices which mine the lived experiences of individuals for the gain of highly privileged researchers and academics (Rose & Kalathil, 2019).

Furthermore, there is an excessive focus on efficiency and outcome, rather than effectiveness and process (Boyle & Harris, 2009), which hinders attempts to coproduce in an ethical and compassionate manner. This is particularly relevant when attempting to coproduce in the context of mental health; one of the main reasons for inviting an EbE into this project was to highlight their perspective as someone with lived experience of long-term mental health difficulties. Unsurprisingly, this comes with the caveat that they may experience mental health difficulties during the time of the project, hence impacting on their capacity for involvement. Unfortunately, we were unable to make sufficient reasonable adjustments to enable WJ-L to continue contributing to the project in a meaningful way due to the pressure of university deadlines. I would argue that this reduced the quality of the work produced, as well as the process by which we produced it. It also failed to achieve the ideals of coproduction by disempowering WJ-L, and privileged researchers' knowledges and institutional processes over lived experiences – thereby perpetuating power imbalances and exploitative practices within clinical psychology research (Rose & Kalathil, 2019).

### **Coproduction in DClinPsy Research: A Roadmap**

Based on our experience of attempting coproduction, WJ-L suggested that we develop a “roadmap” for future trainees to guide their coproduction efforts. Firstly, we recommend that trainees interested in coproduction familiarise themselves with pre-existing

frameworks and research that use this approach, to ensure that they can implement coproduction meaningfully. As Hall et al. (2018) warn, attempts to coproduce research may become tokenistic, have limited representativeness, and a lack of reliable and valid input from EbEs – all of which result in ineffective research practices and outcomes. Oliver et al. (2019) offer three key considerations for coproduction: clarification of motives and outcomes of the research, selection of specific coproduction strategies to meet these aims, and the use of caution and reflexivity in conducting coproductive research. WJ-L recommends that trainees focus on using frameworks flexibly and creatively, as every coproduction endeavour is unique. She warns against using models in a rigid manner which may become tokenistic – for example, becoming so focused on meeting the parameters of a model that you lose sight of the relational elements of coproduction.

Secondly, we recommend that trainees who are considering coproduction invite two EbEs to the research team, and that they do so much earlier in the process – prior to deciding on the research questions and methodology. WJ-L suggests that two EbEs are invited as this reduces the burden on one person, and reduces the need to wait for one person's input (e.g. if they are unavailable due to other commitments or health needs). This may have the additional benefit of expediting the research process. However, we acknowledge that recruiting EbEs earlier may prove challenging as trainees are not able to apply for research funding prior to submission of the research proposal. However, EbE reimbursement can be backdated by up to 3 months, and trainees may be able to negotiate with EbEs to ensure that they can be involved from the first stage of planning and designing the project and reimbursed retrospectively.

Finally, we recommend that EbEs and the research team have open conversations from the start of the project to ensure transparency and troubleshoot potential barriers to coproduction. As highlighted by McCormick-Huhn et al. (2019), these conversations necessarily include an intersectional lens which openly acknowledges and explores power and privilege within the research team, institutions, and processes. The research team will also need to consider how power can be equally distributed given that accountability for

decision-making often lies with the Principal Investigator (Hickey, 2018) and – in the case of trainee research – the trainee retains responsibility for the overall quality and outcomes of the work. WJ-L suggests that key research processes are identified and explained to EbEs at this stage, with an explicit statement of the time required for each process as well as clear communication of expectations of EbEs' input at each stage. This will enable the research team to support EbEs and make reasonable adjustments where required (Government Equalities Office: GEO, 2015). She also recommends that EbEs' training needs are identified in this conversation so that support for learning can be provided earlier, giving the EbEs time to process the information before applying it to the research. Furthermore, WJ-L suggests that the research team discuss the EbEs' other commitments, as well as taking the time to understand EbEs' lived experiences, background, and expertise (e.g. professional expertise) to develop deeper and more meaningful personal relationships within the team.

### **Quality in Qualitative Research**

Historically, the quality of qualitative research was assessed using standards borrowed from quantitative studies – such as reliability, validity, and generalisability (Noble & Smith, 2015). However, there is now consensus that these are inappropriate within the qualitative context, and alternative frameworks have been developed. This section explores generic quality standards for qualitative research, as well as IPA-specific guidance in relation to the research presented in Part 2 of this thesis.

#### **Generic Quality Standards**

Qualitative research focuses on establishing credibility rather than validity or reliability. Noble and Smith (2015) outline the following criteria for assessing credibility in qualitative research: consistency, applicability, and reflexivity. Consistency refers to trustworthiness – whereby the researcher's decision-making is transparently presented for readers to understand the process by which the research was conducted. Applicability refers to researchers' attempts to consider whether findings can be applied across different contexts. Reflexivity refers to the researcher's acknowledgement of multiple realities, and how their epistemological position and experiences inherently influence the outcomes of the

research. Furthermore, Noble and Smith (2015) provide suggestions to improve the quality of qualitative research, such as encouraging researchers to: critically reflect on their own biases as well as systematic sampling biases; keep detailed records of the research process and outcomes; seek for both convergence and divergence in data, and provide rich verbatim quotations of participants' accounts; invite respondent validation and seek to triangulate data.

This thesis endeavours to address each of these points in order to increase the credibility of research processes and findings. Data collection and clear examples of each stage of data analysis are presented in Appendix 4 to demonstrate consistency. To demonstrate applicability, the sample has been situated using demographic information, there has been consideration of how the results may be context-specific, and suggestions have been made relating to broader applications for clinical practice. Reflexivity has been addressed in both Parts 1 and 2 of the thesis; we have presented NA's ontological and epistemological position, and engaged in reflexive practices such as bracketing (Tufford & Newman, 2012), reflective journaling, and supervision. This work aimed to demonstrate the richness of participants' accounts through direct quotations, and sought to explore both similarities and differences across the sample. Although respondent validation was not sought, an EbE was invited to review all stages of data analysis and write-up to improve acceptability and credibility of the work. Furthermore, although participants' accounts were not specifically triangulated using multiple data collection methods, the CRS-15 (Huber & Huber, 2012) was administered to provide an additional layer of richness to participants' accounts.

In addition to following the guidance of Noble and Smith (2015), the Critical Appraisal Skills Programme (CASP) qualitative studies checklist (CASP, 2018) was used to ensure that the thesis contained a sufficient level of detail for readers to assess the quality of this work. APA have published guidelines for authors and reviewers of qualitative research (Levitt et al., 2018) however, the CASP checklist was chosen as it is more concise and covers the same points as APA's standards.

CASP outline 10 key considerations, some of which overlap with those presented by Noble and Smith (2015). CASP criteria which have not been addressed above are presented here, with an explanation of how these criteria were fulfilled in this thesis. A completed CASP checklist is presented in Appendix 7. CASP require researchers to clearly present the research aims and to select an appropriate qualitative methodology. The research aims were presented Parts 1 and 2 of the thesis. IPA is recommended for exploratory research, especially relating to experiential processes, as it enables deeper analysis with fewer participants (Smith et al., 2009). Given that this research was exploratory and focused on service users' experiences of religion, mental health, and therapy, IPA was felt to be the most appropriate methodology.

CASP question whether the research design and recruitment strategy were appropriate for the research aims. This study's design was based on ontological and epistemological positioning (Slevitch, 2011), as well as the exploratory nature of the research – as presented in Part 1. Purposive sampling (Patton, 2007) was used to understand the specific experiences of service users who were religious and had accessed psychotherapy. The option of recruiting from the community in order to understand the experiences of individuals who had either chosen not to access mental healthcare services or who had terminated therapy prior to completion was considered. This would have enabled the gathering of further information about barriers to accessing and remaining engaged with psychotherapy. However, this option was not chosen as it would have resulted in a much larger sample size, which would not be conducive to an IPA approach. Furthermore, recruitment was conducted within the NHS as this is where most UK psychotherapists work, and hence the most relevant context from which to gather data. This work hoped to yield useful suggestions for clinical practice which could be applied in other NHS psychotherapeutic contexts.

CASP require that data are collected in a way that addresses the research questions, and that ethical issues are considered. Data were collected using semi-structured interviews (Rabionet, 2011); this is the preferred data collection method for IPA (Smith et al., 2009),

and enabled exploration of the two main research aims with flexibility. Ethical approval was received from an NHS research ethics committee; the ethics of involving EbEs in research (Rose & Kalathil, 2019) was presented in the coproduction section above. CASP asks researchers to clearly state findings, and to explore the value of the research. This study's findings were presented in Part 2, implications of this work for clinical practice were explored, areas for future research were identified, and applicability of findings to other contexts was considered.

### **Quality In IPA Research**

Generic guidelines for assessing quality in qualitative research are useful as a starting point, but do not offer the nuance required to assess the quality of specific qualitative methodologies. Each qualitative approach has unique challenges and strengths; hence it is important to consider the both overall and methodology-specific quality. Presented below are two key papers which guide quality in IPA research.

Smith (2011) presents four key criteria for IPA studies of an 'acceptable' standard. Studies need to: align with the theoretical principles of IPA; be sufficiently transparent; analysis must be coherent, plausible, and interesting; and demonstrate sufficient density for each theme (e.g. for sample sizes of four to eight, each theme must be supported by at least three participants' accounts). This study has met the criteria for an 'acceptable' IPA paper by providing an overview of the theoretical principles in Part 1, providing excerpts from each stage of the data analysis process in Appendix 4, developing a clear narrative to present results and discussion in Part 2, and ensuring at least three participants' accounts are included within each superordinate theme.

Where these criteria are met, Smith (2011) provides three additional guidelines to ensure that the IPA study is of a 'good' standard: studies offer in-depth and focused analysis; develop a strong experiential account; and the reader finds the paper engaging and enlightening. Nizza et al. (2021) offer detailed guidance for achieving a 'good' standard in IPA through: construction of a compelling narrative, development of a vigorous experiential account, close analysis of participants' words, and focus on convergence and

divergence. In order to provide a focused and in-depth analysis, Nizza et al. (2021) suggest the presentation of a clear 'story', with each quotation supported by a narrative analysis and interpretation. This thesis attempted to fulfil this criterion in Part 2 by presenting quotes which exemplified specific themes, and expanding on the meaning and impact of those passages through interpretative analysis. Nizza et al. (2021) suggest that in order to provide a strong analysis, researchers focus on the existential and experiential significance of participants' accounts and their meaning-making. This thesis highlighted the impact of participants' experiences on their identity, and how this influenced the way they navigated their inter- and intra-personal lives.

In order to closely analyse participants' words, Nizza et al. (2021) recommend that each quote is presented with interpretative analysis, with a focus on language use (e.g. choice of words, repetition, imagery, and metaphor). This can be achieved by paying close attention to the specific quote as well as placing it within the wider context of the participant's transcript. This thesis presented quotes alongside interpretative analysis in Part 2. Finally, Nizza et al. (2021) suggest that convergence and divergence can be demonstrated by presenting commonalities of higher-order constructs, whilst retaining the idiosyncrasies of individual participants' accounts. They recommend that divergence of experience is presented in a way that contextualises participants' accounts within the interview and their wider contexts in order to thicken the narrative. This was demonstrated by the commonalities across participants' accounts, as well as exploration of specific accounts which presented material unique to specific participants

The guidelines for 'good' IPA research are more subjective, and rely on the reader's perceptions of the work. Detailed here are our attempts to meet the criteria for 'acceptable' and 'good' IPA standards; however, we leave it to the reader to ascertain whether we have been successful in doing so.

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## Appendices

## Appendix 1: Ethical Approval

**Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

Tayside medical Science Centre  
Residency Block Level 3  
George Pirie Way  
Ninewells Hospital and Medical School  
Dundee DD1 9SY

Dr John Cape  
Psychological Therapies Programme  
Research Department of Clinical Educational  
& Health Psychology  
3rd Floor, 1-19 Torrington Place  
London  
WC1E 7HB

Date: 30 July 2020  
Your Ref:  
Our Ref: LR/20/ES/0069  
Enquiries to: Mrs Lorraine Reilly  
Direct Line: 01382 383878  
Email: [eosres.tayside@nhs.net](mailto:eosres.tayside@nhs.net)

Dear Dr Cape

**Study Title:** Understanding how service users make sense of their mental health experiences in relation to their religious beliefs, and how this was explored in their individual psychological therapy.

**REC reference:** 20/ES/0069  
**Protocol number:** 132028  
**IRAS project ID:** 280057

Thank you for your letter received on 29 July 2020, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Alternate Vice-chair, Mrs Johan Bennie and Mrs Katherine Coll.

#### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

#### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

#### Registration of Clinical Trials

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Registration is a legal requirement for clinical trials of investigational medicinal products (CTIMPs), except for phase I trials in healthy volunteers (these must still register as a condition of the REC favourable opinion).

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee ( see here for more information on requesting a deferral: <https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/>

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: <https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/>

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **After ethical review: Reporting requirements**

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at <https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/>.

#### **Ethical review of research sites**

##### **NHS/HSC sites**

The favourable opinion applies to all NHS/HSC sites listed in the application subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).



## Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Contract/Study Agreement template [Delegation Log]	1.0	08 June 2020
Copies of advertisement materials for research participants [Participant Recruitment Flyer - Clean copy]	2.0	28 July 2020
Covering letter on headed paper [Cover Letter]	2.1	05 June 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance ]		22 July 2019
GP/consultant information sheets or letters [Contact Slip - Clean copy]	2.0	28 July 2020
Interview schedules or topic guides for participants [Draft Interview Schedule]	1.0	08 June 2020
IRAS Application Form [IRAS_Form_28072020]		28 July 2020
IRAS Checklist XML [Checklist_29072020]		29 July 2020
Letter from funder [Research Expenses Form]		05 February 2020
Letter from sponsor [Funding Declaration Letter]	1	01 April 2019
Letters of invitation to participant [Standardised Recruitment Letter]	2.0	26 July 2020
Other [EOSRES Amendments Cover Letter]		
Other [Consent Form - Track Changes]	2.0	28 July 2020
Other [Contact Slip - Track Changes]	2.0	28 July 2020
Other [Data Flow Diagram - Track Changes]	2.0	28 July 2020
Other [PIS - Track Changes]	2.0	28 July 2020
Other [Participant Recruitment Flyer - Track Changes]	2.0	28 July 2020
Other [Study Protocol - Track Changes]	2.0	28 July 2020
Participant consent form [Consent Form - Clean copy]	2.0	28 July 2020
Participant information sheet (PIS) [PIS - Clean copy]	2.0	28 July 2020
Referee's report or other scientific critique report [Peer Review]	1.0	18 October 2019
Referee's report or other scientific critique report [Peer Review Amendments]	1.0	20 January 2020
Referee's report or other scientific critique report [Peer Review Approval]	1.0	21 January 2020
Research protocol or project proposal [Study Protocol - Clean copy]	2.0	28 July 2020
Sample diary card/patient card [Participant Screening Log]	1.0	08 June 2020
Sample diary card/patient card [Participant Debrief]	1.0	08 June 2020
Summary CV for Chief Investigator (CI) [CI CV John Cape]		16 March 2020
Summary CV for student [CV Navya Anand]		26 March 2020
Summary CV for supervisor (student research) [CI CV John Cape]		16 March 2020



Validated questionnaire [Centrality of Religiosity Scale]		
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### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

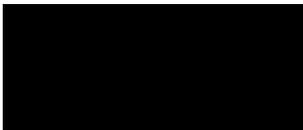
### HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-and-improving-research/learning/>

<b>20/ES/0069</b>	<b>Please quote this number on all correspondence</b>
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With the Committee's best wishes for the success of this project.

Yours sincerely



pp  
**Dr Ian Barker**  
**Alternate Vice-chair**

Email: eosres.tayside@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Delasi Apraku



## Appendix 2: Recruitment Materials

## Participant Information Sheet

**Title of Study:** Exploring religious meaning making in psychological therapy. (Student Study)

### 1. Invitation

You are being invited to take part in a research study as part of a Doctorate in Clinical Psychology degree project. Before you decide whether or not to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish and ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

### 2. What is the project's purpose?

The purpose of the project is to understand how mental healthcare service users make sense of their experiences of mental ill-health in relation to their religious faith, and how this was explored in their individual therapy. By conducting this research, we hope to better understand the meaning-making processes linking religion and mental health, and to uncover the factors which service users find to be more- or less-helpful in initiating and maintaining conversations about religion during individual therapy.

### 3. Am I suitable for this study?

You are being approached as you have religious faith, and have completed a minimum of 12 sessions of individual therapy. In order to be eligible to participate in this study, we ask that you read the following inclusion and exclusion criteria carefully. If you have any questions about your suitability to participate in this research, please contact Navya Anand using the email address listed at the bottom of this form.

#### *Inclusion Criteria:*

- Individuals who have completed individual psychotherapy consisting of a minimum of 12 sessions.
- Individuals who have religious faith.

#### *Exclusion Criteria:*

- Individuals who have terminated therapy early
- Individuals who are yet to begin therapy
- Individuals who have not yet completed therapy.
- Individuals who require an interpreter to communicate with the researcher.
- Individuals living with learning disabilities for whom verbal communication is challenging.

### 4. Do I have to take part?

No; it is up to you to decide whether or not to take part. You can withdraw at any time without giving a reason and without it affecting your physical and mental healthcare in ELFT in any way. If you decide to withdraw from the study prior to the interview stage, all data relating to you will be deleted in accordance with GDPR. If you withdraw from the study after the interview, the interview data will be retained for use in the study, but all identifiable data will be destroyed, and no further procedures relating to the study will be applied to you.

## **5. What will happen to me if I take part?**

You will be asked to read this Participant Information Sheet and the Informed Consent Form that has also been sent to you. You can contact the researcher with any questions or clarifications you may have. If you are interested in participating, please opt in to the study by electronically signing and sending the Informed Consent Form to the researcher via email. If you do not contact the researcher, we will assume that you do not wish to participate in this study and will not contact you further. If you opt in to the study, you will be contacted by the researcher to arrange a date and time for your one-to-one interview. This will take place either via video call (using a free service such as Microsoft Teams or WebEx) or telephone call depending on what works best for you.

The interview will be 90 minutes long in total. The first 15 minutes will be used to ensure that you have understood the purpose of this research, to answer any questions you may have, and to verbally complete a 15-item questionnaire called the Centrality of Religiosity Scale. After this, we will spend 60 minutes on the main interview; this will consist of speaking about your religious faith and how this relates to your experience of mental health difficulties. You will also be asked about how conversations relating to religion and mental health were initiated and maintained in your individual therapy. There will be no breaks during the interview, and we do not expect it to be a distressing experience for participants. However if you find the discussion to be challenging it will be possible to take breaks to enable you to continue with the interview. If the process of the interview is too challenging for you at the time, we will end the interview early.

Once the interview has ended, you will be given further information about the project and given the opportunity to ask any questions you may have, and to withdraw from the study should you wish to do so. This will take approximately 15 minutes. You will be given £15 as a thank you for your participation in this project. You will be given the option of being contacted by the researcher in the Summer of 2021, if you would like to be informed of the outcome of this research (it will be one of the tick-boxes on the informed consent form). If you choose to be contacted, you will be sent an email with a document summarising the main outcomes and learnings from this research.

## **6. Will I be recorded and how will the recorded media be used?**

If you agree to be interviewed, the interview will be audio-recorded. The audio-recording will be used only for transcription and analysis. Quotes from the interview may be used in publications, but not in a way that would identify you. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the recordings. Once the researcher has submitted and passed their Doctorate in Clinical Psychology, all audio recordings and transcripts will be deleted in accordance with Data Protection policies.

## **7. What are the possible disadvantages and risks of taking part?**

We do not anticipate any disadvantages or risks for participating in this study. We appreciate that you are taking time out of your busy schedule to participate in this research.

Due to the nature of these highly personal conversations regarding religion and mental health, it is possible that you may experience some strong emotions during the interview. However, we do not expect that this process will be too distressing, and will ensure that you are not feeling upset prior to leaving the interview.

#### **8. What are the possible benefits of taking part?**

Taking part in this research will allow you to explore how you make sense of your experiences of mental health difficulties in relation to your religious faith, and to reflect on how this was explored in your individual therapy. As this study is completely separate from the mental healthcare that you receive, it will provide a space in which you can reflect on your religion and psychological wellbeing separate from any therapeutic intervention.

#### **9. What if something goes wrong?**

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask your research doctor if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. After discussing with your research doctor, please make the claim in writing to John Cape who is the Chief Investigator for the research and is based at 1-19 Torrington Place. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions, contact details are at the end of the document. If you remain unhappy and wish to complain formally, you can do this via the Patient Advisory Liaison Service (PALS).

Site: ELFT

Address: PALS & Complaints Department, The Green, 1 Roger Dowley Court, Russia Lane

Tel: 0800 783 4839

Email: [elft.palsandcomplaints@nhs.net](mailto:elft.palsandcomplaints@nhs.net)

#### **10. Will my taking part in this project be kept confidential?**

In this research study we will have access to the following information about you: your name, email address, phone number, the length of individual therapy you received and which ELFT Secondary Care Psychological Therapy Service you accessed. People will use this information to do the research or to check your records to make sure that the research is being done properly.

We will also have the information you discuss in your individual interview as an audio recording and in the form of an anonymised transcript. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a

code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

#### **11. Limits to confidentiality**

Confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this was the case we would inform you of any decisions that might limit your confidentiality.

You can find out more about how we use your information at:

- At [www.hra.nhs.uk/information-about-patients/](http://www.hra.nhs.uk/information-about-patients/), UCL website or <https://www.ucl.ac.uk/legal-services/privacy>
- by asking one of the research team
- by sending an email to [navya.anand.18@ucl.ac.uk](mailto:navya.anand.18@ucl.ac.uk) or Sponsor Data Protection Officer [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk) or
- by ringing us on 0203 447 2122.

#### **12. What will happen to the results of the research project?**

The project results will be written up in a report for the researcher Navya Anand's thesis, which is a part of the assessment process for her Doctoral course in Clinical Psychology. The results may also be published in peer-reviewed journals following the completion of Navya Anand's doctorate. The results of the study will also be shared with the clinical teams in ELFT Secondary Care Psychological Therapies Services in the form of presentations delivered in team meetings. In all of these cases, the data will be fully anonymised, and it will not be possible to identify individual participants based on the study results. The data collected for this study will be deleted following completion of the project, and will not be used in any subsequent research.

#### **13. Local Data Protection Privacy Notice**

The controller for this project is University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data and can be contacted at [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk). For information on how UCL uses participant information in research studies click [here](#)

#### **14. Who is organising and funding this study?**

This study has been organised by University College London

#### **15. Who has reviewed this study?**

The East of Scotland Research Ethics Service REC 1, which has responsibility for scrutinising all proposals for medical research on humans, has examined the proposal and has raised no objections from the point of view of research ethics. It is a requirement that our records in this research, together with any relevant medical records, be made available for scrutiny by monitors from UCL and NHS East London Foundation Trust whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

**16. How have patients and the public been involved in this study?**

A member of the UCL Patient and Public Involvement (PPI) team has been involved in the design of this project, and will assist with data analysis as well as dissemination of findings.

**17. Contact for further information**

For further information about this study, please contact:

**Researcher(s):** Navya Anand ([navya.anand.18@ucl.ac.uk](mailto:navya.anand.18@ucl.ac.uk))

**Chief Investigator:** John Cape ([j.cape@ucl.ac.uk](mailto:j.cape@ucl.ac.uk))

**Principal Investigator:** Katerina Daniil ([katerina.daniil@nhs.net](mailto:katerina.daniil@nhs.net))

**Thank you for reading this information sheet and for considering participating in this study.**

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## Participant Recruitment Flyer



# Understanding Mental Health Difficulties In Relation To Religious Faith

### What Does Participation Involve?

You can contact the researcher if you are interested in participating in this research. They will send you further information about the study.

If you decide to take part, the researcher will arrange a time to interview you via video call and you will receive £15 in compensation for your time.

### How Can I Participate?

If you're interested in taking part in this research please speak to your individual therapist or contact the researcher directly at [navya.anand@nhs.net](mailto:navya.anand@nhs.net) or 07806262281

### What's This Research About?

We are trying to understand how religious people make sense of their experiences of mental health difficulties in relation to their religious faith. We are also curious about how this was explored in their individual therapy. Your participation will not affect your mental healthcare, and anything you discuss will be kept confidential with the researcher - these personal conversations will not be shared with your therapist.



### Who Can Participate?

If you are coming to the end of your individual therapy or have finished therapy in the last 18 months, have completed at least 12 sessions, are religious, and are able to communicate in English without the use of an interpreter, you will be able to participate in this study.



Exploring religious meaning making in psychological therapy (Student Study), Recruitment Flyer, IRAS: 280057, Version 2.0 (28/07/2020), REC Reference: 20/ES/0069

## Informed Consent Form

### CONSENT FORM

Title of Project: Exploring religious meaning making in psychological therapy. (Student Study)

Name of Researcher: Navya Anand

Participant Identification Number:

		Please Initial
1	I confirm that I have read the participant information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3	I understand that data collected during the study may be looked at by individuals from University College London (UCL), from regulatory authorities, or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
4	I agree for anonymised quotes from my interview to be used in the write-up of this study.	
5	I agree to take part in the above study.	
6	I give consent for my interview to be audio recorded.	
7	I would like to receive a summary of the results of this study via email once the project has ended. (Optional)	

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person  
taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Thank you for agreeing to take part in this research.

## Appendix 3: CRS-15

Dimension	Items for both the basic and interreligious versions	CRS versions		Interreligious CRSi versions
		Basic CRS versions	Additional Items for the interreligious versions only	
Intellect Ideology Public practice Private practice Experience	01: How often do you think about religious issues? 02: To what extent do you believe that God or something divine exists? 03: How often do you take part in religious services? 04: How often do you pray? 05: How often do you experience situations in which you have the feeling that God or something divine intervenes in your life?	CRS-5	CRS-15	CRSi-20
	06: How interested are you in learning more about religious topics? 07: To what extent do you believe in an afterlife—e.g. immortality of the soul, resurrection of the dead or reincarnation? 08: How important is to take part in religious services? 09: How important is personal prayer for you? 10: How often do you experience situations in which you have the feeling that God or something divine wants to communicate or to reveal something to you?	CRS-10		CRSi-14
	11: How often do you keep yourself informed about religious questions through radio, television, internet, newspapers, or books? 12: In your opinion, how probable is it that a higher power really exists 13: How important is it for you to be connected to a religious community? 14: How often do you pray spontaneously when inspired by daily situations? 15: How often do you experience situations in which you have the feeling that God or something divine is present?			CRSi-7
			04b: How often do you meditate? 05b: How often do you experience situations in which you have the feeling that you are in one with all?	
			09b: How important is meditation for you? 10b: How often do you experience situations in which you have the feeling that you are touched by a divine power?	
Intellect Ideology Public practice Private practice Experience				14b: How often do you try to connect to the divine spontaneously when inspired by daily situations?

<b>Objective frequencies of prayer (personal and obligatory) and meditation</b>	<b>Recoding into five levels</b>	<b>Objective frequencies of participation in religious services</b>	<b>Recoding into five levels</b>
A) Several times a day	5	A) More than once a week	5
B) Once a day		B) Once a week	
C) More than once a week	4	C) One or three times a month	4
D) Once a week		D) A few times a year	3
E) One or three times a month	3	E) Less often	2
F) A few times a year		F) Never	1
G) Less often	2		
H) Never	1		

**Table 4.** Hermeneutics of the wording a five level answer scale.

	<b>Wording</b>		<b>Hermeneutics (presence of personal constructs in personality)</b>
	<b>Score</b>	<b>Importance</b>	
<b>Categories of a five-level answer-scale</b>	5	very often	Clear presence
	4	often	
<b>five-level answer-scale</b>	3	occasionally	Transition area: background presence
	2	rarely	
<b>five-level answer-scale</b>	1	never	No or only marginal presence
		not at all	

## Appendix 4: Data Analysis (Dilshad)

Following each participant's interview, a transcript was generated by Microsoft's free service using the Microsoft Stream platform. I listened back to each interview as I reviewed and edited the transcripts to more accurately reflect the conversation. This often required me to listen to each interview multiple times, and once I had finished transcribing, I would read through the transcript multiple times to familiarise myself with the content and structure.

Presented in this appendix are excerpts from the four-stage data analysis process using material from one participant (Dilshad) to showcase how the analysis progressed.

### Stage 1: Familiarisation

The process of reviewing and editing transcripts as well as reading them multiple times helped me to familiarise myself with the data. Below is a transcript excerpt from Dilshad's interview demonstrating how turn-taking occurred and the flow of our conversation.

**Table 1**

*Excerpt interview transcript.*

Participant	Um so I think there was a point where - and quite a lot of girls, so I went to a girls' school, where you know you sort of wanna wear makeup but you can't because you wear a headscarf. So because I used to wear headscarf- (inaudible) [I: (asks to repeat)] So girls at the school would often want to wear makeup, but you couldn't because you might be wearing a hijab and pick and choose which elements of Islam you follow and pick and choose which elements of Western society you would follow. And I never wanted to be the kind of girl who wears a hijab with a T shirt and is in a pub. I just sort of thought very either all or nothing. So, if I am going to be drinking and smoking and going out clubbing to then go home and pray in front of my family, I would have felt like a hypocrite. So that's why I don't do any of those things anymore. And also 'cause I don't really have a desire to either.
Interviewer	Yeah, so when you say you don't do any of those things which things are you not doing anymore?
Participant	Uh, so in terms of only eating halal me not drinking alcohol, not eating pork or bacon or covering my hair or not talking to boys, or not having sex or praying or fasting. All of those things I don't do.
Interviewer	OK, OK. That sounds like quite a big change from your early life to now. So what does it mean for you to to be at this place with your religion now?
Participant	It can be quite difficult, especially because my family are completely unaware of any of that, so it's almost like I have to have a different persona or different identity. One where I am sort of following my religion and another one where I'm not. I'm definitely - I would like to stay on a surface level happier when I'm not following my religion because I can sort of just live my life and be free. But I'm not sure if there is a part of me that does want to connect to that religion again. Yeah.
Interviewer	Is that something that you thought about before - whether you might want to reconnect?
Participant	I have considered it but it seems very difficult. It's a lot easier to not have to follow my religion. I might- maybe there is a part of me that does want to follow it, but I like drinking and I like not covering my hair so yeah.
Interviewer	Are there any other things that make it difficult to reconnect with your religion?

Participant	I think because it was quite forceful the way it was sort of thrust upon me as a child, which my family have openly said they regret and they wish that they didn't force me to follow the religion. 'cause now they feel like that sort of turned me away. But there's also some very core conceptual things in the religion of Islam that I don't believe in with their role on women and slavery. And, you know, marriage can be from when a child reaches puberty and there's a lot of things in Islam that on a fundamental basis I don't agree with. So while I may have enjoyed in the past the spiritual feeling you get when you pray and I enjoyed as a child going to mosque and seeing my friends, I can't look past that any more. So it is quite difficult to try to reconnect with something that I wasn't as knowledgeable before. I think I only knew about the good things so I enjoyed it, but now, you sort of lift the curtain, and you've seen what's really there.
Interviewer	Hmm. So you said lift the curtain - do you remember when that happened for you?
Participant	So I stopped wearing a hijab at 16, started drinking etc etc and it wasn't until about when I started to teach RE as a subject at a school when I had to do further reading about 24 that I learned all the bad things. I guess you could say not the good things in heaven that your parents teach you about how they teach at mosque - and that was quite disappointing. And then also my father passed away when I was about 26 and I think at the time a lot of people say that kind of thing 'well you know, it's a test from God, it was meant to happen' and people can either become closer to religion in their grief or they can go the opposite way. And I think I definitely took another step back, even further from it at that point.

### **Stage 2: Initial Notes, Stage 3: Emergent Themes, & Reflective Journal**

Following familiarisation, I began data analysis. Stages 2 and 3 were conducted for each participant's data in turn, and comparisons across participants were not made until the dataset was complete in Stage 4.

Stage 2 involves reading the transcript and making notes in the right-hand margin relating to content (descriptive codes), linguistic features (language codes), and underlying meanings (conceptual codes). Historically, IPA researchers would print transcripts and write their notes in the physical margin. However, I used Microsoft Excel to create a column to the right of the transcript whereby I could make these notes and colour-code them based on the type of code. This allowed me to highlight which parts of the transcript related to each initial note, so that I could keep quotes and codes together for the next stage of analysis. The aim of Stage 2 is to reduce the amount of data whilst retaining its depth and breadth. It begins the interpretative process (conceptual codes) whilst remaining close to the raw data (descriptive and linguistic codes).

Following this, I commenced with Stage 3 of analysis whereby initial notes are reviewed to generate emergent themes. Typically, emergent themes are written in the left-

hand-side margin next to the transcript; I created a column to the left of the transcript for this purpose, allowing me to keep related emergent themes, initial notes, and quotes together.

The aim of Stage 3 is to further reduce the volume of data by condensing initial notes into codes that focus on meaning whilst remaining close to the participants' words. Where initial notes may be more descriptive, emergent themes focus on understanding – how the researcher makes sense of the participant's experiences and words. Emergent themes attempt to summarise core conceptual themes related to participants' experiences in short phrases / statements. This stage of the analysis requires links to be made within utterances (e.g. linking shifts in language within a passage of the transcript) as well as across the transcript as a whole (e.g. linking shifts in identity over time). I reviewed initial notes to develop emergent themes, and repeated this process at least once per participant – looking specifically for quotes in the transcript, initial codes, and themes that linked across the interview as a whole.

Immediately following each interview, I made notes of my experience of the interview – including the emotions that were elicited in me, any moments of the interview which stood out to me, and exploring why this might be (based on my lived experiences and assumptions). I added these notes to the Excel document by adding columns to the document to note down my reflections in line with the relevant parts of the transcript. Throughout both Stage 2 and 3, I kept track of my influence on the research by continuing this reflective process – noting down my reactions and thoughts as I conducted the analysis. I also referred to the bracketing interview conducted with WJ-L during this process to track any similar themes that arose.

Initial notes (Stage 2), emergent themes (Stage 3), and the reflective journal are all shown in the analysis excerpt presented below:

### **Figure 1**

*Stages 2, 3, & Reflective Journal*

Emergent Themes	S	Transcript	Initial Notes	Reflections
the ultimate test of faith (bereavement)	I	that's how it panned out?	quite an intellectual emotionally-disconnected answer but the topic is so painful - still too soon to talk about this?	
loss of trust / faith in God	P	It did make me think. I thought I am really cold and clinical in my approach to death, or I'm in denial and I don't wanna emotionally process the death by not associating it with religion and an afterlife. But in terms of what did it mean for me? It just meant that it really solidified for me that a religion or Islam was not gonna get any closer anymore. And if I couldn't find solace in it at a time of death and loss, then how could I really reconcile with it for anything else in the future?	Religion didn't provide solace when they needed it the most - loss of trust in God	
let down by God	I	And what about now looking back at that?	religion didn't help when they were in distress - rejecting religion now in response to that experience of being let down. ?abandoned / rejected	
abandoned by God			'should have needed it most' not 'needed it most' - obligation towards religion? Was unsure of religion even at that time, and resentful that religion didn't help when struggling.	I definitely notice myself slipping into therapist mode with this ppt (even in the interview) - reciprocal roles, and relational patterns to protect the self
resentment towards God				
God fails to protect - God is fallible, God is neglectful	P	I think I still hold the same attitude and I think further reading in Islam has probably just sort of propped that idea up of I don't need it. It didn't help me in a time where I should have needed it most or where people said I would rely on it most. So I definitely don't need it now or want it now. And I sort of play up to it for the sake of my family and keeping the community happy .		
loss of trust in God	I	difficulty. If we had to dig deeper - What did that mean for you? Or what impact did that have on you?		
crisis of faith		There's sort of this moment of crisis. I just remember that after my dad died where I thought, well, if Islam isn't the answer like I've been led to believe, then what? What does it all mean? What is our purpose? Do we really just live and die and then turn to worm meat and you know, and then again and again? And then I sort of - it gives you a bit of an existential crisis where you think, this planet is literally just a speck of sand in a whole massive universe, and then you sort of have well just live life. And then you hit another stage of - well, what is the point in serving a Creator? If he was really merciful, why would he put us through this? And you know that whole debate on why does evil exist if God exists? Which I get, and I understand the arguments for both sides, but once your emotions are attached to it, you can't help but have that feeling of why does a higher power need us to serve him or love him or obey him? He shouldn't have to want that or need that 'cause God surely should have no desire or wants from the things that He creates. I was having all these thoughts in my head. And it made me want to worship or pray even less. If a God could just sort of take things a way that easily.	crisis of faith - questioning the meaning and purpose of life. Repetition of graphic description of physical death - incongruent. Existential crisis - smallness of our existence - grief - hopelessness / helplessness. Spiritual crisis - benevolent God vs punitive God. God as demanding vs God as detached. God has taken something away from me so He does not deserve my faith - ?resentment, anger, revenge	I find it shocking to hear / read these descriptions of the decaying body - I think it triggers my own avoidance of thinking about death, and not wanting to consider the physical degradation of the body of a loved one. Although I'm not religious, I believe in the immortality of the soul and shy away from thinking about physical death to protect myself from painful emotions.
physical death vs spiritual death				
rejecting religious explanations of death / afterlife				
helplessness / hopelessness without God				
God as vindictive (attributing agency to God's neglect / lack of protection)				
resentment towards God	P			

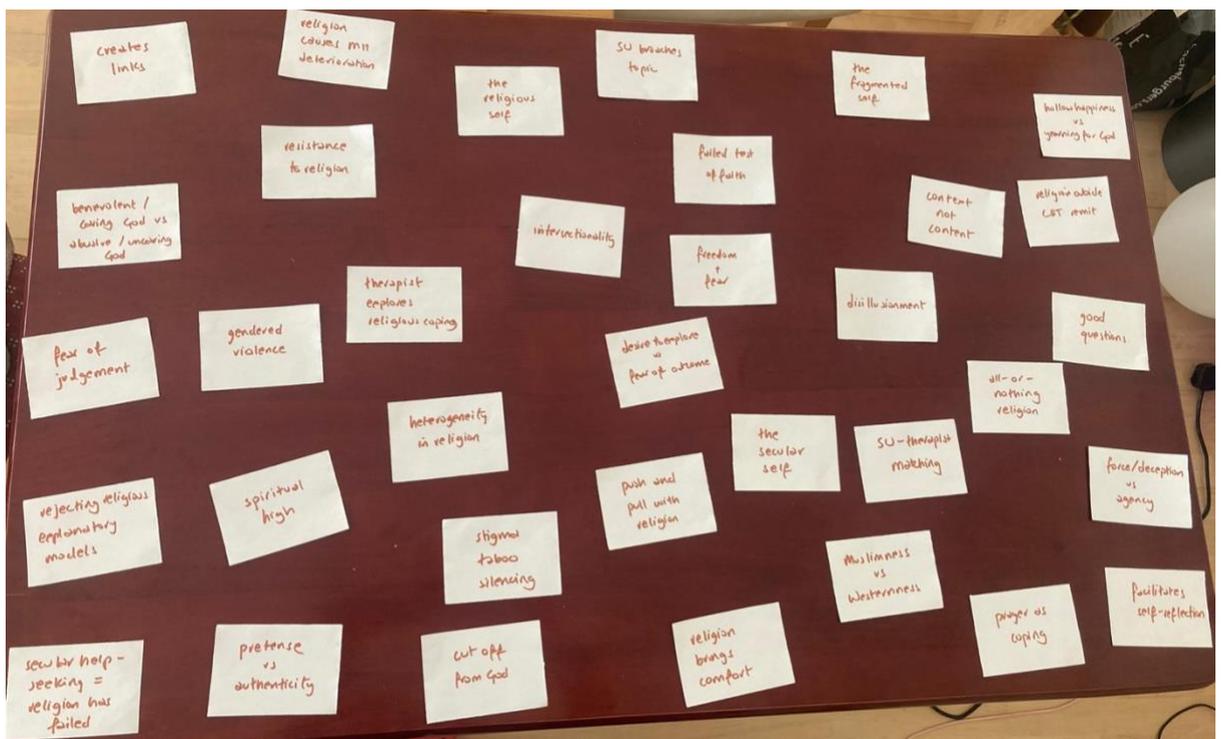
Key: orange = descriptive, blue = linguistic, green = conceptual.

### Stage 3: Emergent Themes

After generating emergent themes across the whole transcript and reviewing them, I began the latter part of Stage 3. This involved writing each emergent theme on a piece of paper and randomly spreading them all out on a table. This allowed me to see all the themes together, and to consider how themes may either move together (with some themes becoming subsumed within others) or may be at odds with each other (i.e. exploring convergence and divergence within an individual's account). Shown below are the themes pre- and post-sorting for Dilshad.

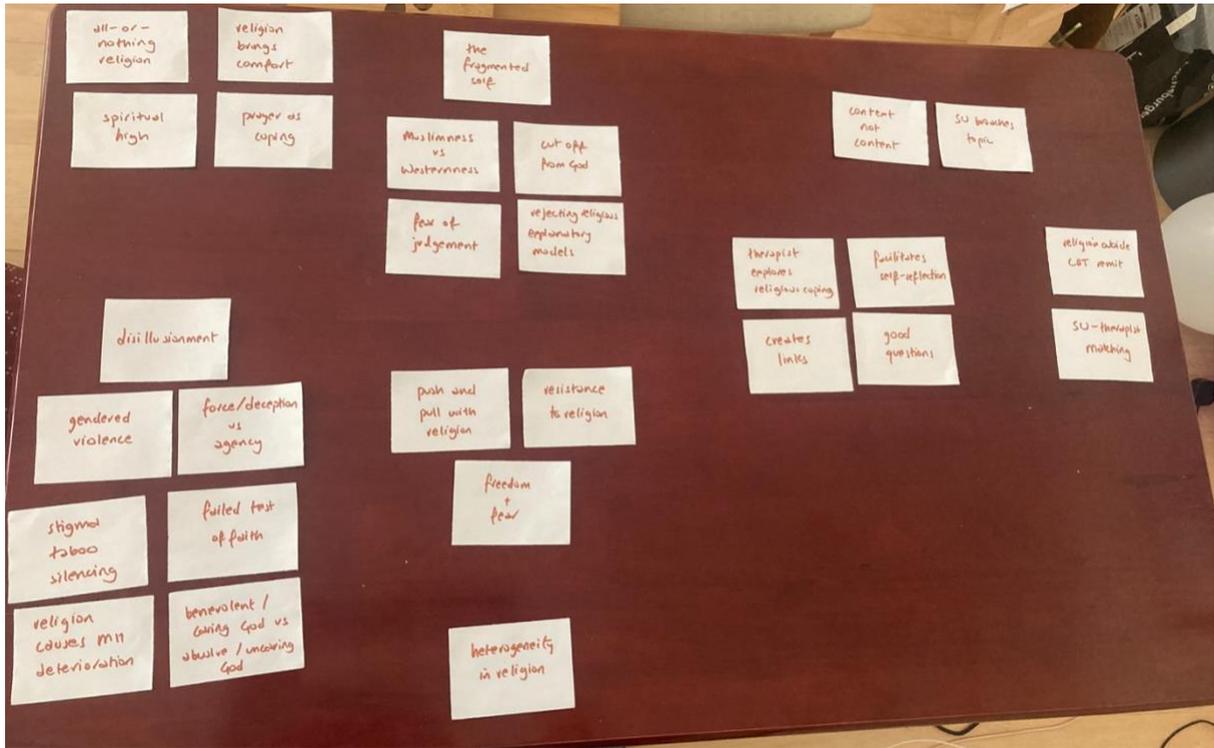
**Figure 2**

*Emergent themes pre-sorting.*



**Figure 3**

*Emergent themes post-sorting*



Following this, I created tables in Microsoft Excel to link superordinate themes with subordinate themes and specific quotes from the transcript. This resulted in a table of emergent themes (with associated sub-themes and quotes) for each participant.

**Table 2**

*Emergent themes – Dilshad.*

Superordinate Theme	Sub-Themes	Quotes
embracing religion	all-or-nothing	"it becomes your identity and nothing else"
	comfort	"it did make it easier in that sense. It's sort of like a fallback where no matter how tough it gets, you know that there's a higher power who's got your back. "
	coping	"there's quite a lot of power to be found in prayer"
	spiritual high	"I remember how much of a spiritual high I would get as well from praying."

		"the root cause of this issue is this person is abusive and I should remove myself from this domestic violence relationship. Whereas Islam is telling me it's just a test - see it through, see it through."
	gendered violence	
	stigma	"the religion is supposed to help us and the religion is being used to the point where we can't talk about it."
	deception vs agency	" I only knew about the good things so I enjoyed it, but now, you sort of lift the curtain, and you've seen what's really there. "
	MH deterioration	" Islam really ruined their mental health. Or their perception of self worth, or what it means to be a woman, or worth, or value. "
	failed test of faith	"if I couldn't find solace in it at a time of death and loss, then how could I really reconcile with it for anything else in the future? "
disillusionment	abusive God	"if all these bad things have happened and there's supposed to be an all-loving all-knowing God, and that's just disappointing."
	Muslimness vs Westernness	"are you British are you Muslim and trying to bridge the gap and integrate that was a struggle growing up"
	fear of judgement	"if you if you don't do this, this will happen to you, and if you don't do that then this will happen for 100,000 years in Hellfire"
the fragmented self	cut off from God	"even if I wanted to feel the presence of a higher being, I don't think I could anymore"

	rejecting religious explanatory models	"Religion has caused their mental health to decline, not their desire to be Western or black magic or anything else."
push and pull		" in an ideal world I would remove all of my negative emotions and attitudes towards my faith. And I would try and find solace and peace and tranquility. And seek out that spiritual high again." "I think the bigger fear is that if I do find some truth in my religion then all of the fear of sinning will come back." "I'm very happy with this sort of coasting situation I've created for myself which is - distance myself from religion, never going to pray again, burying my head in the sand, can't talk to God, can't be spiritual."
heterogeneity in religion		" I do think it's important for them to see that there's not just one generic brand of Islam"
service user's role	reason for seeking therapy	"religion wasn't enough anymore to help me understand what was happening and that's why I sought out therapy"
	context not content	" I only brought it up for context and to provide like background understanding."
	SU raises topic	"I think it was me."
therapist factors	helpful	"she's really good at getting you to really look within yourself" "She had good questioning. So knowing what to pick on, knowing what to go back to, and what to piece together."
	ambiguous	"Had she been the same religion, I would have been scared of judgement. On the flip side, had she been the same religion, maybe she would have got it more"

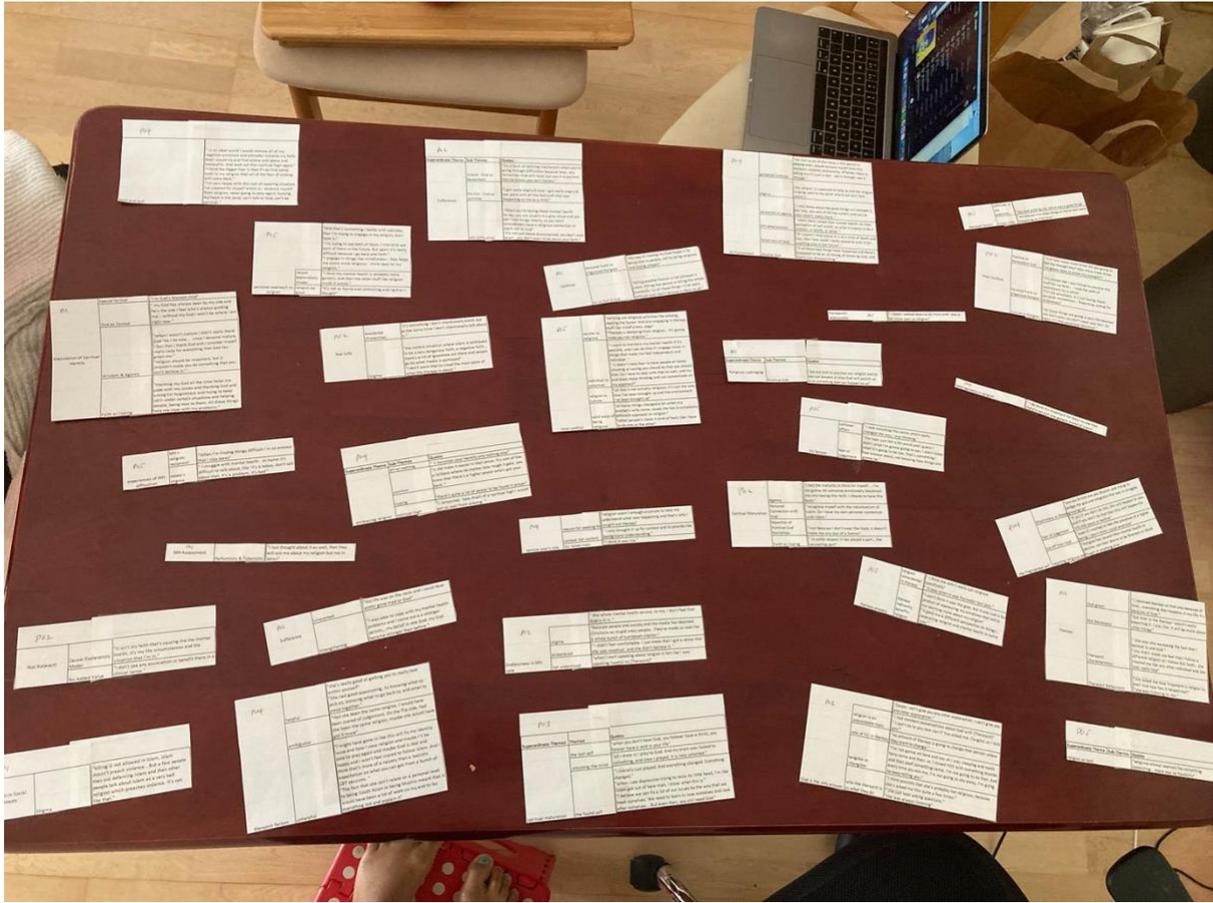
	unhelpful	<p>"I might have gone in like this will fix my identity issue and how I view religion and maybe I'll be able to pray again and maybe God is real and happy and I won't feel scared to follow Islam. And I think that's more of a naivety than a realistic expectation on what you can get from a bunch of CBT sessions."</p> <p>"The fact that she can't relate on a personal level to being South Asian or being Muslim meant that it would have been a lot of work on my end to lay everything out and explain it"</p>
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#### Stage 4: Cross-dataset Analysis

After completing the above stages for each of the five participants, I progressed to Stage 4. This involved printing off and cutting out the superordinate themes (with associated subordinate themes and quotes) for each participant and laying them out randomly on a table. By viewing all of the themes across the dataset, I was able to notice patterns – places of convergence and divergence. Presented below are images of this process pre- and post-clustering.

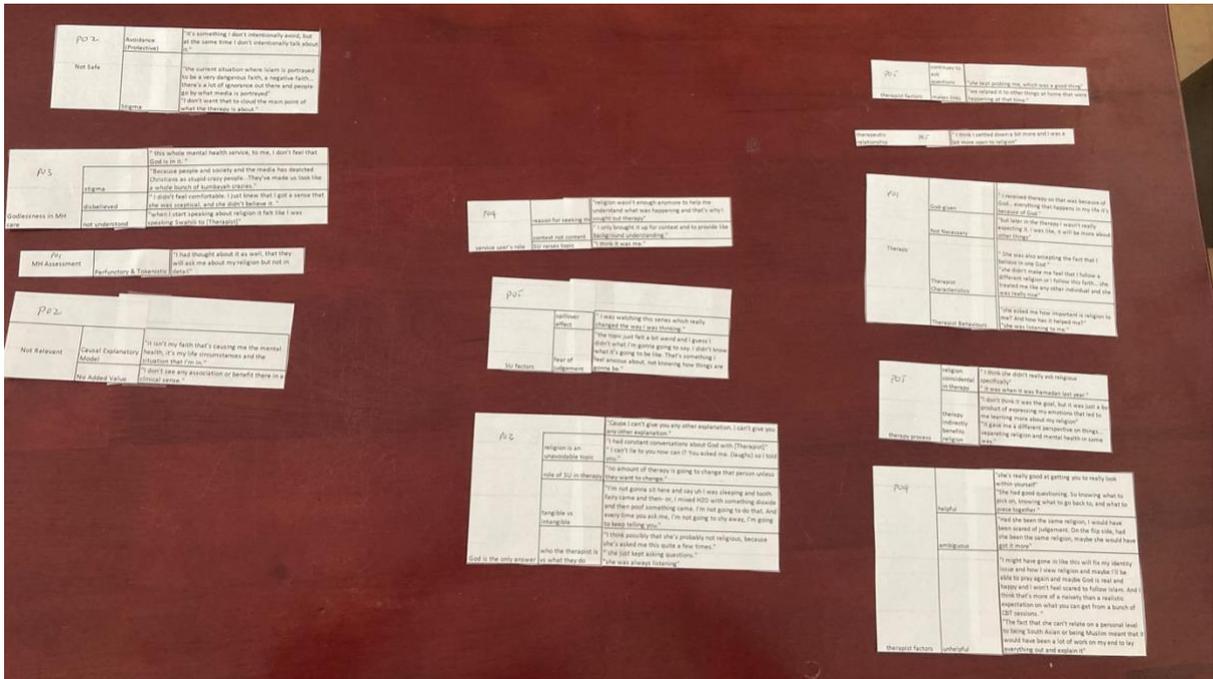
#### Figure 4

*Cross-dataset themes pre-clustering.*



**Figure 5**

*Cross-dataset themes post-clustering.*



Following this, I created a table of cross-dataset themes using Microsoft Excel. At this stage, I revisited each participant’s transcripts, initial codes, and emergent themes to gather quotes which related to the overarching themes that had emerged from Stage 4. This constitutes part of the hermeneutic cycle which characterises IPA research: whereby each step of the analysis and write-up form an iterative process that requires the researcher to revisit the data and reconfigure the analysis as needed. The table below is an excerpt of one of the earlier versions I produced following the completion of Stage 4. This iterative process continued as I began writing up the results in a narrative format – I would revisit participants’ transcripts where the analysis called for a more in-depth exploration of their experiences, or a longer quote was necessitated. This led to more quotes being added to the table of themes and a restructuring of the superordinate themes to reflect those presented in the Empirical Paper.

**Table 3**

*Cross-dataset themes – excerpt.*

Themes	Sub-Themes	Quotes (Participant)
Religious Upbringing		"we are told to practice our religion and to say our prayers or else God will punish us and something bad can happen to us" (P01) "It's almost like I was forced to practice this stuff for my faith... I took the path of resentment for a while" (P02) "religious always seemed like something controlling... there was no flexibility" (P05)

Themes	Sub-Themes	Quotes (Participant)
Disillusionment		<p>"Killing another human is not allowed in Islam. Killing one person is killing the whole humanity. So all these things I find really difficult and I don't believe in them at all." (P01)</p> <p>"You're saying one thing and you're doing another thing. This is not Christianity." (P03)</p> <p>"I only knew about the good things so I enjoyed it, but now, you sort of lift the curtain, and you've seen what's really there." (P04)</p> <p>"oh this is not actually religious, it's just the way how I've been brought up and the environment I've been brought up" (P05)</p>
	Intersectionality	<p>"I don't at all believe in all those things like about homosexuality being illegal in Islam or homosexuality being punishable by death... homosexuals should be punished. I don't believe in all those things" (P01)</p> <p>"The inequality that I faced as a child or growing up in my household isn't to do with religion it's to do with the culture. [] So they believe it's religious reasons why women shouldn't do this women shouldn't do that. Why women shouldn't have the same equality as a man." (P02)</p> <p>"being a woman and then being an Asian woman and then being a Muslim Asian woman in a community like that, mental health is swept under the rug. Female issues are swept under the rug." (P04)</p>

Themes	Sub-Themes	Quotes (Participant)
	MH Difficulties	<p>"When you're having those mental health issues, you are usually in a grey cloud and you can't see things clearly, so you don't immediately have a religious connection or reach out to God" (P02)</p> <p>"Religion has caused their mental health to decline, not their desire to be Western or black magic or anything else." (P04)</p> <p>"I struggle with mental health - at home it's difficult to talk about, like 'it's a taboo, don't talk about that, it's a problem, it's bad'" (P05)</p>

## Appendix 5: Bracketing Interview (Excerpt)

WJ-L	As a student, what made you decide on this particular topic for your research?
NA	So I think it was in my first year of training. I had been working in a secondary care adult mental health service and something that I did notice was that I think without exception, every single person that I worked with had religious faith. But I have received no teaching on how to incorporate religion meaningfully into therapy or how to have those conversations in a helpful way. And then in the summer of that first year, I met up with one of my friends from high school who is of Egyptian Islamic descent and she's she's a practicing Muslim and she has had experiences of chronic long-standing mental health difficulties. And it was just we had this really interesting conversation where I was asking her about how she makes sense of her experiences of mental health difficulties in the context of her Islamic faith. And she was reflecting that no one's ever asked her that before. And actually it's such a huge part of the of the way that she makes sense of the world, but no health care service has ever asked her that question. I think off the back of placement where everyone I was working with was religious and I just felt so lost about being able to help them. And then paired with her saying explicitly no one ever talks to me about this, even though it's so central to my my worldview. Yeah, I think that just really consolidated for me. I was like I have to do some work on this, I have to be the one who fills that gap.
WJ-L	OK, how long ago was that?
NA	Two years ago.
WJ-L	So when you when you started at at UCL you already had this in your mind at the beginning of your training?
NA	Yeah, I think it's sort of built up in that in that first year of training, throughout that year. I don't think I'd even realised it, but it was brewing in the back of my mind. Because I think it made me feel helpless that I had no tools to talk to people who are religious about their faith in a meaningful way.
WJ-L	I'm so so let me let me just see if I get this get get this right. So where you were working you didn't feel equipped to have these conversations with people and able to support them and even throughout your training at UCL that still made you feel unequipped.
NA	Yeah, yeah. And I think I just felt like if they're not teaching me about this, then I need to teach myself almost. And also it felt like. There was a gap there, and when I went away and did a little bit of reading, I found out that actually this kind of research is just not being done that. Psychologists are not asking people with lived experiences of mental health difficulties and who are religious. This question has just not been asked before, and I just felt like it was such a shame because religion plays such a huge role in so many people's lives. And it for me it was just baffling that we are in a field that just ignores that whole aspect of people's lived experience.

[Section Omitted]

WJ-L	Ok, what personal experiences and prior understandings do you bring to this work?
NA	This is this is a point of conflict for me and is one of the reasons that I was so keen to make sure that this project was truly co-produced from the ground up with you. Because I personally I'm not religious even though I've been raised in a Hindu household. In a Hindu culture and I still do participate in all of the traditional festivals and all the praying rituals. And I do all the things behaviourally, but I'm not sure that I have faith. So for me, the influence that my pre understandings have. I guess I think of it quite negatively, but I'm worried that my lack of faith is going to have a really negative influence on the on the process and the outcomes of this research.
WJ-L	How might your your worldview or your religious or non religious aspects influence the recruitment data or the data analysis process?

NA	<p>Well, I'm not religious, so I have a little bit of skepticism. Maybe I don't. I don't know how much that might affect the actual data analysis. Yeah, so I think this is the interesting thing for me. At at the cognitive level, I know that religion brings so much strength and solace and peace for people who have faith. So there isn't any part of me that would invalidate that. But yeah, as you say, I think there is a part of me that for me personally, I don't gain solace or strength or support from faith. So my concern, maybe less so with recruitment, but with the with the analysis itself is that I would worry. I mean realistically I don't think is going to happen because I'd like to think that I'm fairly empathic and wouldn't invalidate people's lived experiences, but I do worry that I might miss things or I might miss the significance of things because I don't have faith, so I might not understand. The underlying meaning or the true religious meaning of something 'cause it's intangible, isn't it? And if I don't have that shared experience, I worry that I might miss what someone is trying to convey to me.</p>
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## Appendix 6: Supplementary Data

Given the iterative process of data analysis and write-up, there are many participants' quotes which constitute the depth of each superordinate and subordinate theme. However, due to word limit constraints, these nuances cannot always be presented in the main body of the paper. Presented below are some additional quotes from across the five participants to add depth and complexity to the analysis presented in the Empirical Paper.

**Table 1**

*Supplementary data*

<b>Personal Religious Journey</b>	
<b>Superordinate Theme (Subordinate Theme)</b>	<b>Quote (Participant)</b>
God as actively punitive (religious upbringing)	<p><i>"It's almost like I was forced to practice this stuff for my faith... I took the path of resentment for a while" (Faridi)</i></p> <p><i>"religious always seemed like something controlling... there was no flexibility" (Rubaiyat)</i></p>
God as actively punitive (suffering)	<p><i>"when you start trying to [live] without God, you end up in the situation which I was in [...] when you're stuck in this situation then, when you're in the jungle fighting the beast" (Ariel)</i></p> <p><i>"the root cause of this issue is this person is abusive and I should remove myself from this domestic violence relationship. Whereas Islam is telling me it's just a test - see it through, see it through [...]if I couldn't find solace in it at a time of death and loss, then how could I really reconcile with it for anything else in the future? [...] Islam really ruined their mental health. Or their perception of self worth, or what it means to be a woman, or worth, or value [...] Religion has caused</i></p>

	<p><i>their mental health to decline, not their desire to be Western or black magic or anything else" (Dilshad)</i></p> <p><i>"I got really angry at God. I got really angry at one point with all the bad stuff that was happening to me as a child." (Faridi)</i></p>
<p>God as actively punitive (disillusionment)</p>	<p><i>"You're saying one thing and you're doing another thing. This is not Christianity." (Ariel)</i></p> <p><i>"I only knew about the good things so I enjoyed it, but now, you sort of lift the curtain, and you've seen what's really there [...] in an ideal world I would remove all of my negative emotions and attitudes towards my faith. And I would try and find solace and peace and tranquility. And seek out that spiritual high again [...] I think the bigger fear is that if I do find some truth in my religion then all of the fear of sinning will come back." (Dilshad)</i></p>
<p>God as ultimately benevolent (suffering)</p>	<p><i>"as Muslims we believe our life has been written out for us before we were born, so I guess this is something I have to go through to to be where I need to be." (Faridi)</i></p>
<p>God as ultimately benevolent (clarity)</p>	<p><i>"The inequality that I faced as a child or growing up in my household isn't to do with religion it's to do with the culture. [] So they believe it's religious reasons why women shouldn't do this women shouldn't do that. Why women shouldn't have the same equality as a man." (Faridi)</i></p> <p><i>"I think my mental health is probably more genetic, and then the other stuff like religion made it worse [...] other things that are religious , that I've learned through therapy what aren't maybe seen as religious on the outside... It's just a different way of getting to the same goal [...] carrying out religious activities like praying, reading</i></p>

	<i>the Quran. And also engaging in therapy stuff like mindfulness, yoga" (Rubaiyat)</i>
God as ultimately benevolent (idiosyncratic religion)	<p><i>"My way of making my God happy is by being nice to people, not by being religious and saying prayers" (Noor)</i></p> <p><i>"I grew up as a Christian but my family weren't really Christians [...] You're saying one thing and you're doing another thing. This is not Christianity. But this is why Christianity has a bad name." (Ariel)</i></p> <p><i>"it doesn't help then to have people at home shouting or saying you should do that you should that. So I have to deal with that as well, and try and block those thinking and just concentrate on my approach" (Rubaiyat)</i></p>
<b>Religion in Therapy</b>	
<b>Superordinate Theme (Subordinate Theme)</b>	<b>Quote (Participant)</b>
Prior understandings (stigma)	<p><i>"Because people and society and the media has depicted Christians as stupid crazy people...They've made us look like a whole bunch of kumbayah crazies." (Ariel)</i></p> <p><i>"the topic just felt a bit weird and I guess I didn't what I'm gonna going to say. I didn't know what it's going to be like." (Rubaiyat)</i></p>
Prior understandings (expectations for therapy)	<p><i>"I knew he will ask me questions and ask me (in assessment) if I follow any religion and if I believe in religion or how important is my faith to me" (Noor)</i></p> <p><i>"in a psychodynamic therapy, my understanding is religion isn't something that you would talk about" (Faridi)</i></p>

Experiences in therapy (introducing religion)	<p><i>" I can't lie to you now can I? You asked me (a question) so I told you - God. I can't say anything else. That's why it was so easy (to discuss religion in therapy)." (Ariel)</i></p> <p><i>"I think she (therapist) didn't really ask (questions about) religious specifically" (Rubaiyat)</i></p>
Experiences in therapy (facilitators)	<p><i>"she didn't make me feel that I follow a different religion or I follow this faith... she treated me like any other individual and she was really nice" (Noor)</i></p> <p><i>"she's really good at getting you to really look within yourself" (Dilshad)</i></p> <p><i>"she kept probing me, which was a good thing [...]we related it to other things at home that were happening at that time." (Rubaiyat)</i></p>
Experiences in therapy (barriers)	<p><i>"I didn't feel comfortable. I just knew that I got a sense that she was sceptical, and she didn't believe it." (Ariel)</i></p> <p><i>"Had she been the same religion, I would have been scared of judgement. On the flip side, had she been the same religion, maybe she would have got it more" (Dilshad)</i></p>

## Appendix 7: CASP Checklist

Paper for appraisal and reference: ..... *Exploring Religious Meaning-making in Individual Psychotherapy* .....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	Y
Can't Tell	
No	

- HINT: Consider
- what was the goal of the research
  - why it was thought important
  - its relevance

Comments:  
*The research aims were explicitly stated at the end of the introduction. the importance and relevance of this research was explained in the introduction. In the discussion, the research aims were revisited and the relevance / importance of this work for clinical practice was explained in detail.*

2. Is a qualitative methodology appropriate?

Yes	Y
Can't Tell	
No	

- HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
  - Is qualitative research the right methodology for addressing the research goal

Comments:  
*The research aims to explore a relatively novel area of research and to extend previous exploratory qualitative work. The focus is on understanding participants' lived experiences and to link this with clinical practice. Qualitative methodology is most appropriate for this exploratory work.*

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes	Y
Can't Tell	
No	

- HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:  
*The research focuses on lived experience (phenomenology) and the chosen methodology aligns with this aim as IPA explicitly enables exploration of subjective experiences. The researcher also acknowledges the role that they play in the process of collecting and analysing the data, which also aligns with IPA's double hermeneutic process.*

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	γ
Can't Tell	
No	

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
  - If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: *A purpose sampling method aiming to recruit from this group was appropriately chosen. In the Discussion of the paper, the author acknowledges how the recruitment method may have influenced results. In the Critical Appraisal, the author explains why the recruitment method was chosen (despite any shortcomings). However there is no discussion about why some individuals may have chosen not to participate in this research.*

5. Was the data collected in a way that addressed the research issue?

Yes	γ
Can't Tell	
No	

HINT: Consider

- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
  - If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
    - If methods were modified during the study. If so, has the researcher explained how and why
  - If the form of data is clear (e.g. tape recordings, video material, notes etc.)
    - If the researcher has discussed saturation of data

Comments: *The author gives a clear rationale for the data collection method and describes the process of data collection in sufficient depth (e.g. providing the semi-structured interview schedule and explaining how this was developed). Data saturation is not relevant to IPA, as stated by the author in the Method section.*

6. Has the relationship between researcher and participants been adequately considered?

Yes	
Can't Tell	Y
No	

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: *The researcher presents their ontological and epistemological positioning. They also provide relevant information about the background of each member of the research team in relation to the topic of the research. The researcher gives evidence of engaging in reflexivity (e.g. bracketing, reflective journal during data analysis). However, it is unclear how the researcher's biases influenced the research and whether they took this into account.*

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	Y
Can't Tell	
No	

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: *The researcher provides ample evidence of applying for and receiving ethical approval, as well as providing recruitment documentation in the appendices.*

8. Was the data analysis sufficiently rigorous?

Yes	
Can't Tell	γ
No	

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
  - To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: *The data analysis process is briefly described in the Method and further evidence is provided in the Appendices. However, there is no narrative explanation of how the researcher conducted the analysis in an iterative manner consistent with the hermeneutic circle of IPA. The researcher provides a rich account of participants' experiences with direct quotations from interviews, and provides evidence of both congruence and dissonance within the sample. The researcher does not critically examine their role during data analysis and selection.*

9. Is there a clear statement of findings?

Yes	γ
Can't Tell	
No	

HINT: Consider whether

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: *The researcher clearly explains how their work relates to broader clinical practice, whilst acknowledging the limitations of their work. The researcher addresses the credibility of their work briefly in the Discussion and further in the Critical Appraisal. The results are linked explicitly to the research aims.*

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

*The researcher explores how their results contribute to clinical psychological understandings and practices, and explains how their work extends that of previous researchers. The Discussion identifies areas for future research as well as possibilities for transferability of the research.*