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What does spirituality mean to black and minority ethnic people with mental health problems?
An interpretative phenomenological analysis

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What Does Spirituality Mean to Black and Minority Ethnic People with Mental Health Problems? An Interpretative Phenomenological Analysis

By

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Abstract

Spirituality is recognised as a vital element of mental health care however the spiritual needs of individuals remain neglected. Although current studies examine the understanding of spirituality in mental health, the meaning of spirituality from the perspective of Black and Minority Ethnic (BME) people facing mental illness remains unclear. Mental health services in Britain serve an ethnically diverse population therefore, this research explores how people with mental health problems from a BME background experience spirituality and what it means to them to further an understanding of spirituality as a key element of mental health support.

Semi-structured interviews were conducted with five individuals with mental health problems which provided rich and detailed narratives about personal spiritual experiences. An interpretative phenomenological analysis was employed to focus on how each person made sense of their experience of spirituality while dealing with mental illness.

Three distinct themes emerged from the analysis which illustrated that spiritual and religious beliefs can play a beneficial role for some people through providing a range of coping mechanisms while others may experience negative consequences associated with spiritual beliefs. Overall, within these narratives there was a sense that spiritual and religious beliefs were complex and highly individualised, regardless of religious denomination.

This study provides an insight into the meaning of spirituality to individuals with mental health problems which adds to the current knowledge development on the potential role of personal spiritual experiences in supporting people with mental illness. The analysis demonstrates that at the heart of spiritual care is the concept of an individualised approach which may help practitioners to pay particular attention to the personal meaning of spirituality as part of a person-centred approach to mental health care.

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Chapter 1

Introduction and Literature Review

> "*At its best, our National Health Service is there when we need it, at the most profound moments in our lives. At the birth of our children. At the deaths of our loved ones. And at every stage inbetween - as we grapple with hope, fear, loneliness, compassion - some of the most fundamental elements of the human spirit*."
>
> Simon Stevens, Chief Executive of NHS England (NHS England 2015: 5).

We all depend upon healthcare at the most vulnerable stages of life and spiritual beliefs may be fundamentally essential to individuals when dealing with the challenges of ill health. In relation to mental illness, mental health problems are increasingly recognised as a global health concern and represent one of the leading causes of ill health worldwide (Vos, Barber and Bell et al 2013). Within the UK, the prevalence of mental distress in England is highlighted in statistics from the Adult Psychiatric Morbidity Survey (APMS) which shows that one in six people experiences a common mental health problem in any week, while one in three people with a common mental disorder are receiving mental health treatment (McManus, Bebbington and Jenkins et al 2016). For many people, spirituality is critical to coping with the devastating impact of mental health problems which was highlighted in a literature review on spirituality and mental health published by The Mental Health Foundation (MHF 2006). Spirituality is therefore a necessary component of healthcare and the subject of this research however, despite the importance of spirituality, research (MHF 2006, Swinton 2001) has shown that spirituality in mental health care is often neglected.

The purpose of this first chapter is to provide the structure of the thesis and to review the current literature on spirituality in the field of mental health nursing. I begin by providing an outline of each chapter followed by considering the importance of spirituality and mental health and an exploration of the key healthcare policies which provide guidance for spiritual care. The main themes of the current literature are discussed which includes issues concerning the definition of spirituality, the relationship between spirituality and mental health and matters in relation to spiritual care.

1.1 Thesis Structure

This study sets out to explore the meaning of spirituality to Black and Minority Ethnic (BME) people with mental health problems. The principal aims of this research are:

1. To explore the unique lived experience of spiritual beliefs in relation to BME people living with a mental illness.
2. To examine the role spirituality plays for BME people with mental health problems.
3. To advance scholarship in the area of spirituality and mental health from a UK perspective.

Following the first chapter which introduces the current literature concerning the significance of spirituality within mental health care, chapter 2 presents a systematic literature review on the experience of spirituality for people with

mental health problems. The rationale, review methods and data synthesis are provided which lead towards the reasons for the study and the development of the research question.

Chapter 3 presents the research methodology with a description of the theoretical underpinnings of Interpretative Phenomenological Analysis (IPA) and the rationale for the selection of the approach to study the meaning of spirituality and mental health. IPA was selected to understand the meaning of the human lived experience of spirituality and dealing with mental illness. Chapter 4 provides a detailed account of the research methods with a presentation of the research design which was underpinned by the IPA approach which is followed by an introduction to the research participants. Participants from community mental health support groups were invited to participate in the study.

Chapter 5 presents the research findings. The analysis produced three superordinate themes and seven emergent themes which illustrate the powerful meaning of spirituality to each participant. In chapter 6 the specific findings of the IPA research are discussed within the context of the wider literature to address the research question. Key recommendations are made for mental health practice, education, policy and future research. Finally, chapter 7 concludes the thesis by specifying how this research expands current knowledge on the meaning of spirituality to people with mental health problems.

The next section considers the link between spirituality and mental health nursing.

1.2 Spirituality and Mental Health Nursing

1.2.1 The importance of spirituality and mental health

The relationship between spirituality and health has been the subject of increasing interest in recent years, yet the concept is one of deep historical origin. The link between spirituality and health was closely aligned in the past with religious communities caring for the sick (Koenig, King and Carson 2012). In the eighteenth century, spiritual care was provided in the form of moral treatment which involved the humane treatment of people with mental illness, however this was not the case in all asylums which were criticised for neglect and brutality (Porter 2002: 104-117). The relationship between spirituality and health is one which continues within today's healthcare.

On a global scale, the importance of spirituality is identified by the World Health Organisation (WHO) in which emphasis is placed on the need for greater recognition by health professionals of the value of beliefs in relation to healthcare in a move towards a broader holistic view of health, rather than continuing to follow a medical model of treatment which provides a reductionist view of the person (WHO 1998). Spirituality has been recently included within health assessment (WHO 2002) however, debate continues around the issue of including spiritual needs in the WHO definition of health. In relation to the legal obligations of the NHS to acknowledge spirituality, the Human Rights Act (1998)

sets the requirement to make provision for the religious and spiritual needs for people receiving care.

The importance of spirituality and mental health is demonstrated by the Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group which explores the role of spirituality to strengthen mental health treatment. In addition, the position statement of the World Psychiatric Association (Moreira-Almeida, Sharma and van Rensburg et al 2016: 87) states that there should be an understanding of the relationship between religion and spirituality in relation to the diagnosis and treatment of mental illness.

The significance of spirituality is indicated by the diversity of faiths and beliefs within the UK population. In the 2011 UK Census, the majority of the population of England and Wales identified with a formal religion, while around a quarter of the population (14.1 million people) declared that they had no religious affiliation (Office for National Statistics 2012). Christianity was the largest religion accounting for 59% (or 33.2 million) of the population, Islam was the second most prevalent religious group with 5% (or 2.7 million people), and 4% of the population identified themselves with other religions which reflects a vast array of beliefs in the UK today suggesting possible implications for patients' healthcare needs. My experience of working as a mental health nurse in a multicultural inner-city area is where my personal interest began into the connection between spirituality and mental health. I gained insight into how frequently religion arises in the experience of mental illness, yet the concept of

spirituality was not recognised as a priority in mental health care where I practiced locally.

1.2.2 The importance of spirituality for nursing

The importance of spirituality for the nursing profession is explicitly stated as a requirement by the Nursing and Midwifery Council (NMC) within the professional standards for competence for pre-registration nursing education. Newly qualified nurses are expected to have the skills to provide holistic care which includes the assessment of a person's spiritual needs (NMC 2018: 13). In addition to the professional expectation to provide spiritual care, the relationship between spirituality and nursing is directly driven by the Department of Health within healthcare policy. Recent decades have seen a cultural shift in policy documents which have acknowledged the growing prioritisation of spiritual care.

As a reflection of the WHO recommendations to provide holistic care, several documents have increasingly focused attention on the healthcare needs of the whole person. This was seen in the publication of 'The Patient's Charter' which drew attention to the responsibility of the National Health Service to care beyond the physical needs of people and to recognise spiritual needs as part of holistic care (DH 1991). Greater emphasis on the spiritual dimension followed in 'The NHS Plan' (DH 2000: 4) which outlined how increased funding was being used to improve care and acknowledged the need for respecting patients' religious beliefs. Supplemented by 'Your Guide to the NHS' (DH 2001) and the

‘National Service Framework for Mental Health’ (DH 1999) national standards were provided at policy level and key interventions were identified for meeting patients’ spiritual and religious needs which was seen as fundamental to NHS care. Furthermore, The NHS performance framework ‘Standards for Better Health’ (DH 2003) set out the expected standards of NHS care and stated that staff needed to recognise spiritual needs which showed the continued commitment of policy to the acknowledgment of spirituality.

Specific practice guidelines for particular areas of healthcare have already recognised the value of spirituality and feature recommendations for effective spiritual care, such as the guidance from the National Institute for Health and Excellence (NICE) for palliative care (NICE 2004). The guidelines encourage the integration of spiritual aspects of care as an integral part of palliative care to support people with the impact of a life-threatening disease. It states that spiritual care is the responsibility of all staff and where a person’s needs cannot be met, multidisciplinary teams should have access to consult other resources or team members to respond to the need for spiritual care. Speck (2005: 30) suggests that although the guidance is specifically intended for the palliative care of people with cancer, the recommendations are relevant across other domains of healthcare.

Although spirituality was not explicitly mentioned in the national policy which followed, the documents ‘Modernising Nursing Careers: Setting the direction’ (DH 2006) and ‘Our NHS, Our Future’ (DH 2007) presented the view

of the need for personalised care to meet the needs of a culturally diverse society. It was in 2009 that key policy which was specifically dedicated to spirituality in healthcare was introduced by the Department of Health entitled 'Religion or Belief' which served to underline the values of beliefs in healthcare. In particular, the publication highlighted the volume of research which demonstrated the important role of spiritual and religious beliefs in the recovery from illness. The document reiterated the message of the requirement for a holistic approach to care, one in which clinicians understand the importance of religious belief within the context of people receiving healthcare.

The value of chaplaincy in the provision of spiritual care has also been the focus of policy. Guidance on the role of NHS Chaplaincy was issued by the document 'Caring for the Spirit: A strategy for the development of chaplaincy and the spiritual healthcare workforce' (South Yorkshire Workforce Development Confederation 2003). This was the first policy document to give attention to promoting the work of chaplains and the spiritual needs of patients as part of modernising healthcare. It reinforced the importance of the provision of spiritual care in which NHS chaplains work as members of multidisciplinary teams across a range of care settings. Similar practice guidance was found in 'NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff' (DH 2003) which provided a framework for chaplaincy to address spiritual needs across the NHS. The document indicated that spiritual care must be equal and respectful to people of all beliefs, including care provision for people who describe themselves as not religious. In March 2015, the chaplaincy

guidelines (NHS England 2015) were revised to emphasise the importance of chaplaincy care to be accessible for people of all faiths and beliefs, again including those who are not religious which reflects the rich diversity of beliefs within our multicultural society.

1.3 Spirituality and Mental Health Policy

Spirituality has been a recurrent theme in mental health policy across a number of publications and significant developments in the understanding of spiritual care have taken place in mental health care. The central role of spirituality in recovering from mental illness was highlighted by The National Institute for Mental Health in England (NIMHE 2005). Twelve guiding principles for mental health recovery were outlined, two of which stated that recovery is more effective when spiritual needs have been considered as part of holistic mental health care. In relation to mental health nursing specifically, a number of policy documents have advocated the integration of spiritual care. The importance of recognising spirituality was expressed by the Department of Health within the policy 'From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing' (DH 2006) which set out to improve the experience of mental health care. It recommended that mental health nurses should be equipped with the skills to provide care that integrates spiritual needs as part of the holistic approach to see the individual as a whole person. Spiritual care was made explicit by the review in which one of the key recommendations for Mental Health nursing stated that all Mental Health nurses must 'recognise and respond to the spiritual and religious needs of service

users' (DH 2006: 38). The recommendation included that service providers supported Mental Health nurses with accessible sources of information and advice concerning spiritual and religious issues.

Alongside the review of mental health nursing and the findings from NIMHE, guidance for mental health staff was provided by Gilbert (2008) in 'Guidelines on Spirituality for Staff in Acute Care Services'. The purpose of the document was to raise awareness of the meaning of spirituality for staff to bridge the gap in understanding. Similarly, NHS Education for Scotland (2009) published guidance for NHS staff 'Spiritual Care Matters' which signaled developments in the understanding of how to provide spiritual care as a vital aspect of mental health care.

The policy 'No Health without Mental Health' (DH 2011) repeated the recommendation to encompass a person's religion or belief within mental health assessment to understand the core features of individual identity for the achievement of successful treatment outcomes. This document differed by highlighting the potential protective role of religion or beliefs for people with mental health problems and specified the need for people to express their religious beliefs such as through having access to a prayer room which is echoed in the chaplaincy guidelines (NHS England 2015). Respect for beliefs has therefore become a critical element of care for mental health professionals.

There has been a strong consensus that healthcare needs to change towards a person-centred approach which treats the individual as a whole person. This has been followed by the present policy messages of 'The Five Year Forward View' (The Mental Health Taskforce 2016) and the 'Personalised Care and Support Planning Handbook' (NHS England 2016). Despite the fact that spirituality is not explicitly mentioned in either of these documents, they extend the view that the NHS needs to provide an inclusive, person-centred approach in which the person, rather than the illness, is at the heart of care which parallels the purpose of spiritual care.

The NHS is now celebrating its 70th anniversary and whilst the recurrent policy recommendations over a number of years have supported the importance of spiritual care, difficulties consistently arise in relation to insufficient resources (Healthcare Chaplaincy Network 2017: 3) when attempts are made to implement the policies in mental health services today. Spirituality is often misunderstood (McManus 2006: 24) resulting in significant gaps, with many people living with mental health problems reporting that their spiritual needs are unmet (Macmin and Foskett 2004). This section has provided an overview of the relevant policy frameworks which support the importance of spiritual care. The following section explores the main themes of the current literature in relation to spirituality and mental health beginning with the definition of spirituality in mental health care.

1.4 Current Literature Themes

1.4.1 The definition of spirituality

A considerable amount of literature has been published on spirituality and mental health care, much of which pays particular attention to issues in relation to the definition of spirituality. Spirituality is a term frequently used in the literature, but it is difficult to define and to date there is no consensus on a universal meaning of the term (Corry, Lewis and Mallet 2014: 91, Ellis and Narayanasamy 2009: 886, Greasley, Chuiu and Gartland 2001, Guthrie and Stickley 2008: 388, Hadzic 2011: 228, Koenig 2012: 2, McSherry and Cash 2004: 156, Mohr 2011: 550, Nolan and Crawford 1997, RCPsych 2013: 4). The concept of spirituality is broad (Koslander, da Silva and Roxberg 2009: 35) and embodies a multitude of personal and distinct meanings for different people therefore, it is argued by some that a single definition is problematic to apply due to the subjective and multifaceted nature of spirituality (Chan 2009: 2129, Koenig 2009: 284, McSherry and Cash 2004: 154, McSherry, Draper and Kendrick 2002: 723, Narayanasamy 2004, Tischler, Biberman and McKeage 2002).

Various definitions of spirituality are therefore found in the literature which raises a number of difficulties. Reinart and Koenig (2013: 2) examined definitions of spirituality within nursing research and found at least 20 different concept analyses published in the literature in two decades which indicates a vast number of definitions and therefore a lack of clarity. Ellis and Naryayanasamy (2009: 886, McSherry and Cash 2004: 151-158) suggest that

the danger of multiple definitions and meanings is confusion and a limited understanding in which the meaning of spirituality can lose significance or value. McSherry and Cash (2004: 152, McSherry, Draper and Kendrick 2002: 724) suggest it is assumed that nurses and those receiving care understand the meaning of the term 'spirituality' yet in reality, the concept evades a shared language which leads to difficulties in providing spiritual care.

Debate continues about the definition of spirituality and although there are differences of opinion, attempts have been made to define the meaning of the concept. One example is an agreed definition of spirituality which is provided by a multidisciplinary international expert group, representing medical, psychological and spiritual disciplines.

> 'Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, science, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices.' (Puchalski, Vitillio and Hull et al 2014).

The description captures the key attributes of the concept which are shared across a range of definitions. Spirituality is described as a human experience with social, personal and traditional factors, which is similarly expressed by definitions from both the Royal College of Psychiatrists (RCPsych 2013: 4) and Swinton (2001).

> 'Spirituality is that aspect of human existence that gives it its "humanness". It concerns the structures of significance that give meaning and direction to a person's life and help them deal with the vicissitudes of existence. As such, it includes such vital dimensions as the quest for meaning, purpose, self-transcending knowledge, meaningful relationships, love and commitment, as

> well as (for some) a sense of the Holy amongst us.' (Swinton 2001).

The need for meaning and purpose in life is a significant characteristic of spirituality in the definitions within the literature (Cook 2004, MHF 2008, Puchalski, Ferrell and Viriani 2009, Naryanasamy 2004: 1140, Swinton 2001). Clarke (2006) however, criticises the use of the term 'meaning' in relation to spirituality which is argued to be unlimited and subjective with the potential for negative understandings. The term implies that anything that provides a person with meaning can be considered to be spiritual leading to the expectation that negative beliefs such as racist views could be construed as spiritual. Clarke (2006) suggests a more helpful term is 'conditional meaning' in which nurses assist people to find the meaning of the situation they find themselves in which will be used to help people to get better. Most definitions of spirituality share other core attributes in relation to personal beliefs, experiences and values and a feeling of connection to self and others (Huguelet and Koenig 2009: 1, MHF 2008, Moreira-Almeida, Koenig and Lucchetti (2014: 177, RCPsych 2013: 4-5, Swinton 2001, Swinton and Parkes 2011: 48). In addition, spirituality is defined as being unique to the person and a source of inner strength (Gilbert 2008, MHF 2008).

Religion and spirituality are distinct but related concepts which are often combined in the literature, adding to the difficulty of defining each concept (Heffernan, Neil and Weatherhead 2014: 222). In some definitions, spirituality may, but not necessarily, overlap with religion (Huguelet and Koenig 2009: 1,

MHF 2008, Moreira-Almeida, Koenig and Lucchetti 2014: 177, Swinton 2001, RCPSych 2013) in other cases it is described by some people as distinct from religion and personally defined (Koenig 2009: 284, Tanyi 2002). Religion is defined as structured beliefs, rituals and practices which concern the sacred such as God or a higher power and are shared by faith communities (Dein, Cook and Powell et al 2010, Koenig 2009: 284, Moreira-Almeida, Koenig, Lucchetti 2014: 177, RCPsych 2013: 4, Swinton and Parkes 2011: 48). In its position statement on spirituality and mental health, the Royal College of Psychiatrists (RCPsych 2013: 4-5) present the view that there is variation in the scope of the definitions in that for some people, the concepts of spirituality and religion are combined, while for others, spirituality and religion are seen as opposing concepts. However, at the heart of both spirituality and religion is the focus upon beliefs, values and human experience which has a potential impact on people with mental illness.

Koenig, King and Carson (2012: 45) provide a similar definition of religion with reference to the involvement of 'beliefs, practice and rituals related to the transcendent… religion is also an organised system of beliefs, practices and symbols designed to facilitate closeness to the transcendent, and to foster an understanding of one's relationship and responsibility to others in living together in a community.' In this definition the specific view of transcendence is in contrast to the thirty-five meanings of transcendence identified by Maslow (1993: 259-269) which has implications for nursing practice. Religion may also be included with spirituality which is expressed in the following definition of

spirituality, ‘a connection to that which is sacred, the transcendent…intimately connected to the supernatural, the mystical and to organised religion.’ (Koenig, King and Carson 2012: 46). The definitions illustrate the broad elements of the concept and that for some people, spirituality may be related to religious practice.

There has been criticism of the definitions of spirituality and religion within the nursing literature. Concern has been expressed that the definitions of spirituality are primarily based on the personal understanding of researchers rather than upon theoretical evidence (Clarke 2009, Hadzic 2011: 228, Paley 2008, McSherry and Cash 2004: 152). Furthermore, the broad definitions of spirituality have been heavily criticised by Paley (2007, 2008) which he claims are stretched to embrace every human experience in order to justify spirituality in a secular society. His criticism of the extended meaning of spirituality argues that the term ‘spiritual needs’ is being used to replace what is currently understood to be the psychosocial and existential needs of people and therefore the concept of spirituality adds little contribution to the identification of healthcare needs. Paley (2008) ultimately argues for a secular UK health service to meet the needs of a secular population.

In addition to the subjective interpretations of the concept, Clarke (2009) argues that the definitions have been accepted without critical thinking and consequently, has led towards bias and confusing terms which are difficult to articulate and problematic to implement in clinical practice. Clarke (2009: 1671)

highlights the dangers of attempting to define spirituality in which a major concern is the risk of developing professional language which has no meaning for the public, creating a divide between nurses and patients whereby patients do not understand spirituality and struggle to express their spiritual needs.

Alternatively, a suggested way forward is that spirituality should not be confined to a single definition but instead, open to interpretation in specific situations and therefore tailored to the individual and their culture (Pike 2011, Swinton 2006). Similarly, Hadzic (2011: 228) raises the importance of context-specific definitions to acknowledge the array of different cultural and religious meanings of spirituality that exist within different religions. In addition, Dein (2005: 526) questions the appropriateness of the terms 'spirituality' and 'religion' in the context of cross-cultural psychiatry by presenting the view that for some cultures and religions, the concepts are integrated therefore it would be unhelpful to distinguish between spirituality and religion for all people. This view is supported by McSherry and Cash (2004: 152) who argue that definitions of spirituality may lack cultural sensitivity in that the language may not be acceptable to all faiths and cultures therefore the construction of a single definition of spirituality is unachievable.

The differences between the methods used to research spirituality are also a contributing factor to the problems of definition. Swinton and Parkes (2011: 48) suggest that differences exist between research in the United States which has focused on religion and research in the United Kingdom which has

used the term ‘spirituality’, therefore adding to the confusion of the concept. The variation of definitions used within the nursing literature was reviewed by Reinart and Koenig (2013) who found that multiple definitions led to inconsistencies in research outcomes. They argue that conducting quantitative research demands a consistent definition of spirituality which is inclusive of religion to enable the measurement of health outcomes and therefore, should be distinguished from the broader definitions which are more appropriate to qualitative research and clinical care. Narayanasamy (2004, Parkes 2010: 38) however, express the view that the significance of spirituality and personal belief cannot be defined or measured and is consequently not conducive to quantitative research.

The concept of spirituality is a prominent theme in the literature and yet it is difficult to define precisely. There are a number of issues associated with defining the term spirituality yet McSherry and Cash (2004: 159) suggest that rather than focus on definition, insights into the meaning of spirituality should be generated from qualitative research with patients, clinicians and diverse cultures to develop a common understanding that is relevant for clinical practice and the NHS person-centred approach to care.

1.4.2 The relationship between spirituality and mental health

A central theme within the literature is the association between spirituality and mental health. The importance of spirituality to mental health is acknowledged by the 2016 position statement of the World Psychiatric

Association which proposes that there should be an understanding of the relationship between spirituality and mental health concerning the diagnosis and treatment of mental illness (Moreira-Almeida, Sharma and van Rensburg, et al 2016: 87). Systematic reviews of literature which examine the relationship between spirituality and health have identified over 3000 studies (Koenig, King and Carson 2012, Koenig, McCullough and Larson 2001). The bulk of evidence supports the positive relationship between spirituality and mental health (Cook 2011: 9, Hadzic 2011: 223, Hefti 2011: 611, Moreira-Almeida, Lotufo and Neto et al 2006, RCPsych 2013: 5) however there may also be harmful effects from spiritual and religious beliefs (RCPsych 2013: 5).

1.4.3 The positive impact of spirituality on mental health

In general, numerous qualitative studies suggest that spirituality and religious beliefs are associated with better mental health (Greasley, Chi and Gartland 2001, Koslander and Arvidsson 2006, Wilding, Muir-Cochrane and May 2006). Spirituality can be a protective factor and be a core feature of the recovery process from serious mental illness (Baetz and Toews 2009, Basset, Lloyd and Tse 2008: 254, Gilbert 2008, Koenig 2009, Wilding, May and Muir-Cochrane 2005, Suto and Smith 2014: 18, Wong-McDonald 2007). Patients with mental illness often draw upon religion and spiritual beliefs to provide the capacity to cope with the experience of serious illness (Dein 2010: 28, Hadzic 2011: 226, Hodge 2004: 37, Cornah 2006, Mohr 2006) and have stated that religion and spirituality is of great significance in their lives (Borras, Mohr, Gillieron et al 2010: 77, Huguelet, Mohr, Brandt et al 2006, MHF 1997,

Russinova and Cash 2007). In an Australian study of 79 psychiatric patients, 79% of participants specified the importance of spirituality in their lives, while 67% identified that spirituality had been used to cope with mental illness (D'Souza 2003). In addition, Hefti (2011: 611) reports that religious or spiritual beliefs are used by 70-80% of patients with mental illness to cope with daily problems.

The benefits of spirituality for mental health are shown in the evidence from nearly 500 quantitative studies which demonstrate that religion enhances coping and adjustment (Koenig, King and Carson 2012: 301). The findings are supported by literature reviews conducted to explore the research on the relationship between spirituality and mental health (Koenig 2009, Koenig 2012). The reviews have concluded that religion may help people to cope with mental illness which is enabled through the provision of comfort, hope and meaning to difficult circumstances.

Other aspects of mental health are found to benefit from spirituality and religion such as increased levels of hope, happiness, optimism and life satisfaction (Koenig 2009, Koenig, King and Carson 2012: 301-302, Koenig 2012, Mela, Marcoux and Baetz et al 2008: 529), meaning and purpose (Hefti 2011: 611, Koenig 2009, Koenig 2012, Koenig, King and Carson 2012: 302), enabling people to live with mental illness. In addition, spirituality can have positive effects upon self-esteem (Hefti 2011: 613, Koenig, King and Carson 2012: 303). Mohr (2011: 550, Mohr 2006) suggest that distress may be

minimised by the benefits of hope, purpose and meaning from spiritual beliefs, which may be associated with social integration and community support.

Spirituality and religion have been found to have a positive impact on a range of mental disorders. In their systematic reviews of the research published prior to the year 2000 and since the year 2000, Koenig, King and Carson (2012: 303-304) reported that overall, lower rates of depression were found in people with religious beliefs in 61% of 413 observational studies, and 63% in clinical trials and experimental research. Specifically, the review revealed that in research published since the year 2000, 63% of 272 cross-sectional studies discovered inverse relationships between spiritual beliefs and depression. In addition, the review found that 47% of 45 prospective cohort studies reported lower levels of depression with religious and spiritual involvement. Further evidence was reported within the review from 22 clinical trials or experimental studies, of which 64% discovered decreased rates of depression associated with religious and spiritual beliefs.

Additional studies indicate that religious and spiritual beliefs are associated with the alleviation of stress and decreased levels of depression. Goncalves, Lucchetti and Menezes et al (2015) conducted a systematic review of religious and spiritual interventions through randomized controlled trials and discovered reductions in stress and depression as a consequence of spirituality. Similar findings were discovered in a study by Mela, Marcoux and Baetz et al (2008: 529) in which 183 forensic mental health patients were surveyed which

revealed the association between religiosity and decreased depression. Spirituality and religion therefore play a significant positive role in the lives of people suffering from depression.

Religion may have an impact on the risk of suicide attempts. Koenig, King and Carson (2012: 304) found since the year 2000, 67% of at least 70 quantitative studies have reported fewer suicide attempts or completed suicides among people with religious and spiritual beliefs. Reduced levels of suicide are also supported by Dein (2010: 28, Koenig 2012: 7, Van Praag 2009). Cook (2014: 254) highlights that most of the findings which indicate that spirituality protects against suicide are based upon cross-sectional research which identifies the relationship but is limited in examining the meaning of the connection. More understanding therefore, is needed about the role of spirituality and religion in relation to suicide. The majority of religions have held negative attitudes towards suicide (Cook 2014: 254) yet religion may also be a positive influence in the reduction of suicide attempts through reducing levels of depression and facilitating social support, hope and meaning (Koenig, King and Carson 2012: 179-180). Alternatively, a Randomised Controlled Trial (RCT) by Ramos, Erkanli and Koenig (2018) reported that religion has no effect on suicidal thoughts. The study compared the effects of religious Cognitive Behaviour Therapy (CBT) with conventional CBT for people with major depression and found no significant difference in suicidal ideation which suggests that further RCTs are needed to investigate causality more conclusively.

Spirituality and religion have been found to contribute to improved mental health in relation to decreased levels of anxiety (Bonelli and Koenig 2013, Goncalves, Lucchetti and Menezes et al 2015, Hefti 2011: 613, Koenig 2010, Koenig 2012: 7, Mela, Marcoux and Baetz et al 2008: 529, Moreira-Almeida, Neto and Koenig 2006). Koenig, King and Carson (2012: 304) identified at least 299 studies both in the review prior to 2000 and since 2000 which have examined the relationship between religion, spirituality and anxiety, of which 49% have found reduced levels of anxiety associated with religion and spirituality.

Spirituality has been found to have a positive impact on psychotic disorders (Hefti 2011: 613). According to a review of evidence by Koenig, King and Carson 2012: 305), 43 studies were identified of which 33% found fewer psychotic symptoms in religious people, while 23% found greater levels of symptoms for reasons which are not specified by the authors. The majority of the studies were cross-sectional and a limitation of these methods is the lack of opportunity to observe changes in individuals over time (Maltby, Williams, and McGarry et al 2014: 39-40). Six prospective or experimental studies however, provided a different picture which indicated that four of the studies demonstrated a positive impact of spirituality leading to stable symptoms. Research on the relationship between schizophrenia and spirituality has been conducted in Switzerland and the findings indicate that individuals frequently turn to religious practice and experience a close relationship with God to cope

with the symptoms of psychosis such as hearing voices and may also help with medication compliance (Mohr and Huguelet 2004, Mohr, Brandt and Borras et al 2006, Mohr, Gillieron and Borras 2007). Hadzic (2011: 227) suggests that the explanation for the close relationship between spirituality and people with schizophrenia is unclear and therefore further research is required. For people suffering from psychosis, spirituality and religion has been found to provide a sense of hope, purpose and meaning in life and increase social contact which helps people to cope with illness.

Research reviewed on the relationship between substance misuse and spirituality has found decreased levels of substance abuse (Borras, Mohr and Brandt et al 2007, Cook, Goddard and Westall 1997, Hefti 2011: 613, Huguelet and Koenig 2009, Koenig 2010, Koenig 2012: 7, Moreira-Almeida, Neto and Koenig 2006, Bonelli and Koenig 2013). In relation to alcohol abuse, a review of the literature found 278 studies, of which 86% have found inverse relationships between alcohol use and religion and spirituality (Koenig, King and Carson 2012: 305). In relation to drug abuse, of 180 quantitative studies 86% reported fewer rates of substance abuse among people with religious or spiritual beliefs which highlights the positive influence of spirituality within care.

In a review of the research on the relationship between religion, spirituality and bipolar disorder, Pesut, Clark and Maxwell et al (2011) found that religion and spirituality may be important for people with bipolar disorder. However, the evidence is limited as few studies have focused upon the

association of spirituality and bipolar disorder while the majority of research which is concerned with spirituality and mental health has focused specifically upon depression, anxiety, substance misuse and psychosis to examine the relationship between spirituality and mental health (Koenig 2010, Koenig 2012, Pesut, Clark and Maxwell et al 2011: 786). Further research is therefore required in this area to determine the nature of the relationship with spirituality.

The specific reasons behind the benefits of spirituality for mental health are yet to be understood (Hadzic 2011: 223). The positive relationship between spirituality and mental health may be due to several factors which Dein (2006, Swinton and Parkes 2011: 49-50) suggest may include drawing strength from greater social support through receiving care and caring for others, positive emotions, coping resources, assistance with developing healthy living in relation to alcohol and substance abuse, support and positive self-esteem from a personal relationship with God which all contribute towards a sense of purpose. Koenig, King and Carson (2012: 303) found in their review that spirituality and religion is positively associated with social support. 82% of 74 studies demonstrated a relationship between spirituality, religion and social support while 53% of 17 studies found decreased loneliness among people with religious or spiritual beliefs. In addition, Koenig (2012: 7) highlights that the relationship between religion and mental health is explained by the rules for living provided by religion. Religious practice identifies how to treat other individuals with compassion, promotes social support, encourages values such as honesty, forgiveness and patience and condemns the use of substances

which are all factors that can help to manage stress levels and lead to positive mental health.

1.4.4 The negative impact of spirituality on mental health

Despite the studies that have found a positive relationship between spirituality and mental health, some evidence points towards the negative effects of spirituality on health (Dein 2010: 28, Hadzic 2011: 230). Although spirituality is a resource for comfort, hope and meaning, religious belief can become integrated with mental illness (Cohen and Koenig 2004, Koenig 2010: 116) such as greater levels of anxiety, depression and religious delusions. For a minority of people with psychosis, social isolation and spiritual despair have been reported in relation to spiritual and religious beliefs (Hadzic 2011: 227). There are times when spirituality and religion may have a negative influence on mental health through enhancing feelings of guilt and dependency (Dein 2013: 1, Hefti 2011: 611) leading to greater levels of distress. It may therefore be difficult to ascertain if beliefs are beneficial or a cause of harm (Koenig 2009).

Spirituality and religion may have negative effects on mental health through religious conflicts with God, such as anger and discontent, which may contribute to greater distress. Exline, Park and Smyth et al (2011) examined anger towards God across five studies and discovered the association between religious anger and depressive symptoms. In addition, mental illness can deteriorate through dealing with rejection from religious groups on the basis of mental illness (Mohr 2011). Feelings of rejection may become reinforced by

religious groups who have negative perceptions of mental illness (Hefti 2011: 611) for example, the understanding of mental illness among some Muslim communities can lead to prejudice and marginalisation (Ciftci, Jones and Corrigan 2013).

Contrary to the extensive body of evidence which concludes that religion and spirituality are beneficial to mental health (Koenig, King and Carson 2012, Koenig 2012) a UK study has found that spirituality can be a factor in poorer mental health. The relationship between religion, spirituality and mental health was explored in a national survey of over 7000 people in England (King, Marston and McManus et al 2012). The findings concluded that people with spiritual beliefs in the absence of any organised religious framework are more vulnerable to mental illness and were reported to have the worst mental health. It appeared that better mental health was experienced by those who held neither religious or spiritual beliefs. They report that similar findings have been found in a number of UK studies in which religious and spiritual beliefs are linked to poorer health (King, Speck and Thomas 1994, King, Speck and Thomas 1999) and poorer mental health is evident where spiritual beliefs exist in the absence of religion (King, Welch and Nazroo et al 2006). Although the conclusion of the study suggests that spirituality in the absence of religion is more likely to cause mental disorder, it can be argued that a limitation of the research is that it cannot prove cause and effect in relation to spirituality and mental health (King, Marston and McManus et al 2012). The study was a cross-sectional survey which is useful to highlight the link between spiritual

beliefs and mental health however, it cannot prove that spirituality causes mental illness, only the relationship between the two factors at one point in time and so reverse causality cannot be excluded. Further evidence is therefore required to understand the effects of spirituality in relation to mental illness. Cook and Powell (2013: 385) suggest that the conclusion of the study which claims that spirituality is bad for mental health is one that is misleading. In contrast to the findings, Cook and Powell (2013: 385) argue that spiritually informed therapies are used successfully in the treatment of substance abuse (Cook 2009) and depression (NICE 2009). In response, King (2013: 386) suggests that the main finding of the study should be interpreted as spirituality has no advantage in relation to mental health, rather than as an element which is bad for mental health. The debate indicates that the evidence from the cross-sectional study is perhaps insufficient to determine a conclusion about the links between spiritual beliefs and mental health.

Religious beliefs may have negative effects upon mental health for some people with psychosis who may experience religious delusions, while some people may remain in distress with increased depression and anxiety through reinforced fear or guilt however, on balance studies support the view that overall religious involvement has positive associations with mental health (Koenig 2009: 289) however, these studies have their limitations as discussed further below.

1.4.5 General study limitations

Although it is indicated that religion is associated with better mental health, King, Marston, McManus et al (2012: 1) draw attention to the fact that in some studies the concept of wellbeing is integrated with religiosity therefore the measurement of the religion can be problematic. A further limitation is that the majority of research is from the United States involving Judeo-Christian religious beliefs from White populations in North America and has not included a diverse range of people with different forms of spiritual beliefs (King and Dein 1998). In addition, religious differences need to be recognised with spirituality being defined according to the context of specific religions (Hadzic 2011: 223), cultural factors need to be acknowledged in relation to spiritual beliefs (Milstein, Maniere and Yali 2010) and measurement scales used in research need to account for a range of religious differences (Dein, Cook and Koenig 2012).

Further criticism concerns the shortcomings of the research methodologies whereby the evidence is predominantly focused on measuring religious activity in the form of systematic reviews of randomised controlled trials (Goncalves, Lucchetti, Menezes et al 2015). While providing high quality evidence about religiosity, the measurement of spirituality through quantitative research can be enhanced with qualitative research conducted on broader elements of religion and spirituality. Pargament, Koenig and Perez (2000: 521) argue that research should examine how individuals use religion as a coping mechanism, rather than the measurement of church attendance and prayer to determine religious coping.

Other concerns have been expressed concerning the limited research conducted on non-religious populations to explore the impact of their spiritual beliefs on mental health (Hwang, Hamer and Cragan 2009). Guthrie and Stickley (2008: 390) argue that few studies examine the role of spirituality for people receiving mental health care. Swinton and Parkes (2011: 49) suggest that the deeper personal meaning behind religious activity is of great importance and is often not addressed in research which quantifies religious practice. Qualitative research on the correlation between spirituality and mental health is limited which is perhaps a result of the difficulty in scientifically analysing the experience of spirituality (Swinton 2001). Despite these issues, the findings indicate that religious practice is linked to better mental health and recovery (Koenig, King and Carson 2012).

In summary this section has examined the evidence concerning the relationship between spirituality and mental health. Spiritual and religious beliefs can play a positive role in people's lives enabling coping with mental illness. On the other hand, spirituality can however have a negative impact on mental health causing greater distress. An understanding of the complexities within the relationship has implications for spiritual care.

1.4.6 Spiritual Care

Much of the current literature on spirituality pays attention to issues concerning spiritual care. NHS Scotland (2009) defines spiritual care as a concept in which support is provided through human contact in response to the

human spirit when an individual is struggling with needs such as illness, crisis or sadness. Mental health professionals recognise the importance of spirituality as a fundamental concept in the context of healthcare (Dura-Vila, Hagger, Dein et al 2011: 58) yet spiritual needs are widely reported to be neglected by professionals in clinical practice (Borras, Mohr and Gillieron et al 2010: 77, D'Souza and George 2006: 410, Dura-Vila, Hagger and Dein et al 2011: 58, Heffernan, Neil and Weatherhead 2014: 223, Galanter, Glickman and Dertmatis et al 2008, Holyland and Mayers 2005, Thompson 2002: 33, Koslander and Arvidsson 2005, 2007, MHF 2008, Mohr 2006, Ross 2008: 859, Wilding, Muir-Cochrane and May 2006). The Healthcare Commission (2008) reported that spiritual needs were documented in only 32% of service user records which highlights that spiritual needs are not being adequately addressed. The neglect of spiritual needs is suggested by Galanter, Dermatis and Talbot et al (2011) to illustrate a divide in the attitudes towards spiritual care between policy level and the mental health professionals who implement care.

One example of the reasons for the lack of spiritual care is the priority given to the medical model of treatment. Mental health professionals are reported to focus upon the medical aspect of illness and omit spiritual issues from assessment and treatment which conflict with the medical model of care (Dura-Vila, Hagger and Dein et al 2011: 58, Macmin and Foskett 2004). Contrary to the emphasis of healthcare policy recommendations on holistic care, it is argued that caregiving in mental health is dominated by a medical view of physiological needs and treatment which excludes patients' spiritual

needs and points towards a reductionist view of mental illness (Koslander, da Silva and Roxberg 2009: 34-39). Spiritual care is therefore neglected by health care professionals who perceive the individual with mental illness purely from a medical perspective.

Additional reasons for the inadequate provision of spiritual care emerged from a survey conducted by the Royal College of Nursing (RCN) which examined 4054 British nurses' perceptions of spiritual care and revealed that nurses across all specialities believe that spirituality is a core element of high quality nursing care however, a number of barriers are encountered by staff (McSherry and Jamieson 2011, RCN 2011: 27). One of the barriers highlighted by the survey is the lack of confidence in addressing spiritual needs which is evident in the consensus among nurses for additional guidance and education concerning the concept of spirituality as part of the nursing role (RCN 2011: 27). This view is supported by evidence which points out that nurses and psychiatrists (Borras, Mohr, Gillerion et al 2010: 77) are confused about the concept of spirituality and are uncertain about what constitutes providing spiritual care as part of their role (Healthcare Chaplaincy Network 2017: 3, Koslander and Arvidsson 2005: 564, Naryanasamy 2004: 1140, Narayansamy and Owens 2001). Cook (2012: 39) argues that the responsibility of spiritual care lies with all healthcare professionals and is not only the role of chaplains.

Whilst nurses recognise the value of spiritual care, the literature claims that many nurses have expressed insufficient knowledge about spiritual issues

and feel unprepared to provide spiritual care (Chidarikere 2012: 300, Culliford 2002: 1435, Elliot 2011: 8, Ellis and Narayanasamy 2009: 888, Healthcare Chaplaincy Network 2017: 3, Koslander and Arvidsson 2005: 564, Koslander, da Silva and Roxberg 2009: 58, RCN 2011, Ross 2006: 853). In addition to these challenges, economic factors such as poor resources and time constraints are encountered by staff as a barrier to addressing spiritual needs (Borras, Mohr, Gillerion et al 2010: 77, Chan 2009: 2130, Culliford 2002: 1435, Dura-Vila, Hagger and Dein et al 2011: 58, El-Nimr, Green and Salib 2004: 169, Healthcare Chaplaincy Network 2017: 3, Isaac, Hay and Lubetkin 2016: 1072, Lee and Baumann 2013: 2, McBrien 2006: 45, Narayanasamy and Owens 2001, Pullen, McGuire and Farmer et al 2015: 17, Ross 2006: 853). Mental health professionals therefore face a range of inter-related challenges which threaten the provision of spiritual care.

Religion is often overlooked as a coping strategy by psychiatrists (De Fazio, Gaetano and Croleo et al 2015: 234) yet people with mental health problems have identified the importance of spirituality as a resource in their lives (Basset, Lloyd and Tse 2008: 254, Borras, Mohr and Gillieron et al (2010: 77, Chidarikere 2012, Hodge 2004, Koenig 2008, Russinova and Cash 2007, Sullivan 2009) and the increasing desire to have spiritual needs addressed by services (Cook 2012: 39, D'Souza 2002, D'Souza and George 2006: 409, Elliot 2011: 4, Heffernan, Neil and Weatherhead 2014: 230, Puchalski 2013: 491, RCPsych 2013: 5-9). The perspective of people with mental health problems supports the need for spiritual care however, when diagnosed with a mental

disorder spiritual beliefs are often misinterpreted as symptoms of mental illness by some clinicians therefore service users are fearful to discuss spiritual and religious matters with mental health professionals for the risk of being viewed as mentally unwell (Bassett, Lloyd and Tse 2008: 254, Gilbert, Kaur and Parkes 2010: 29, Greasely, Chuiu and Gartland 2001, Heffernan, Neil and Weatherhead 2014: 230, MHF 2002, MHF 2007, MHF 2008, Mohr 2011). Macmin and Foskett (2004) reported that service users wanted to talk about their spirituality which they viewed as a resource for their suffering yet they reported that staff ignored their spiritual needs or interpreted spiritual issues as signs of mental illness. Consequently, service users are in a difficult position in which spiritual care may be desired but there is reluctance to discuss spirituality through the fear of their beliefs being pathologised as manifestations of mental illness.

Clinicians are reported to be equally cautious about the effects of addressing spiritual needs. In the context of acute psychiatric units, health care professionals may feel confused and challenged by the idea of engaging in conversations about spirituality (Baetz and Toews 2009, Galanter, Glickman and Dermatis et al 2008). It is suggested that one of the reasons why spiritual issues are not addressed by psychiatrists is that religion often presents within the context of pathological delusions or hallucinations (Lee and Baumann 2013: 2). Mental health professionals are reported to avoid discussing spirituality and religion for the fear of exacerbating mental illness (Borras, Mohr and Gillerion et al 2010: 77-83, Foskett 2001: 406, MHF 2008). Foskett, Marriott and Wilson-

Rudd (2004) published a survey which revealed that 45% of mental health professionals across a range of disciplines believed religion could contribute to mental health problems, while 39% felt that religion was a protective factor in mental health. A further example is from a Canadian study which explored the experience of mental health professionals having spiritual conversations with service users on acute psychiatric units (Suto and Smith 2014). The research found that clinicians experienced challenges in distinguishing spiritual expression from symptoms of psychosis and some participants feared that discussing spirituality may cause greater psychological harm. Consequently, spiritual conversations were avoided with service users who were perceived to be vulnerable due to psychosis. In contrast, transpersonal psychiatrists have explored how to differentiate spiritual emergency from mental illness (Grof and Grof 1990: 247-264) which has implications for clinicians addressing spiritual needs. A spiritual emergency is identified as a psychological transformation in the absence of medical illness. The transformation centres around spiritual themes in life such as birth, death and transpersonal experiences. Traditional psychiatry may interpret the symptoms as mental illness which has consequences for offering effective support.

Alternatively, there are circumstances in which clinicians feel comfortable to discuss spirituality. Lee and Baumann (2013: 6) found that the majority of German psychiatrists in their research prefer to allow patients to initiate discussion about spiritual matters, rather than routinely include religion and spirituality in mental health care. Similarly, Foskett (2001: 406) discovered that

mental health professionals relied upon the service user to initiate a spiritual discussion. Spiritual beliefs which manifest as mental illness highlight the complexity of providing spiritual care in mental health services.

In contrast to the avoidance of spiritual discussion, the lack of spiritual conversation in mental health care may be perceived as a further challenge in the provision of spiritual care. Huguelet, Mohr and Brandt et al (2006) found that psychiatrists did not discuss religious beliefs with service users and often had little awareness of their patient's spiritual beliefs. It is claimed that spirituality is absent from the language of nursing and consequently needs to be reintroduced into mental health care (Nolan and Crawford 1997: 291). The importance of the language used to discuss spiritual care was highlighted by the RCN's survey (2011) in which it was recommended that patients should be asked about their perceptions of spiritual care. The concept of spirituality may not be understood by some service users therefore, there may be a mismatch between the patients' perception of spirituality and that of the health professional (McBrien 2006: 44). In addition, McSherry and Watson (2002: 843-844) suggest that nursing lacks a common language of spirituality which is understood by both staff and patients therefore patients should be asked for their perceptions of spirituality to develop a shared understanding of spiritual needs to ensure that spiritual care is meaningful to the individual. The need for further research is supported by Koslander and Arvidsson (2005: 558) to examine the way in which patients articulate their spiritual needs.

The self-awareness and personal beliefs of practitioners may be an influential factor in the provision of spiritual care. Staff may be reluctant to discuss spiritual concerns if they feel uncomfortable or personally challenged about their own religious beliefs (Chidarikere 2012: 300, Isaac, Hay and Lubetkin 2016: 1072, MHF 2008). Chung, Wong and Chan (2001: 167) studied the relationship between the spirituality of nurses and the understanding of spiritual issues in care. They concluded that personal religious and spiritual beliefs influence the understanding of spiritual care therefore constant self-awareness is required. In order to be competent to recognise and discuss the spiritual needs of mental health patients, it is essential for nurses to develop an awareness of their own spiritual issues to understand the value of spiritual care (Chan 2009: 2128, Chidarikere 2012: 300, Ellis and Narayanasamy 2009: 889, Koslander and Arvidsson 2005: 565-560, Koslander, da Silva and Roxberg 2009: 58, Merchant, Gilbert and Moss 2008: 2, Nolan and Crawford 1997: 291, Ross 2006: 853). Furthermore, Attard, Baldacchino and Camilleri (2014) recommend self-reflection as a tool for nurses to develop spiritual competency in their study into the effects of teaching spiritual care. The importance of self-awareness and spiritual competency is raised by Hodge (2013: 225) who argues that service users may question the self-awareness of mental health professionals concerning spirituality and therefore may be hesitant to disclose spiritual issues until they are certain that the clinician is competent and trustworthy in relation to spiritual matters.

Spiritual care may be overlooked by professionals if they fail to identify with a particular faith (Hadzic 2011: 227). A concept referred to as a 'religiosity gap' describes the fact that mental health staff may be less religious than service users (Cook 2011: 9). In relation to psychiatrists in particular, evidence suggests that many psychiatrists are less likely to have religious beliefs in comparison with service users (Baetz, Griffin and Bowen et al 2004: 265, Borras, Mohr and Gillieron et al 2010: 77, Dein, Cook and Powell et al 2010, Neeleman and Persaud 1995) therefore spirituality is not valued as a fundamental factor in care. In a worldwide literature review, Cook (2011) examined the evidence of a religiosity gap between psychiatrists and patients and found evidence which supported the view that psychiatrists are less likely to be affiliated with religious beliefs than service users however, more evidence is required to determine the size of the 'religiosity gap'. In contrast, Dura-Vila, Hagger and Dein et al (2011: 61) found that the majority of the psychiatrists in their UK study were affiliated to a religion and recognised the importance of spirituality in clinical practice however, spiritual issues were not routinely addressed. Furthermore, a study which explored German psychiatrists' interpretation of religion and spirituality revealed that the more religious psychiatrists are, the more likely they are to recognise spirituality as a positive aspect of mental health care (Lee and Baumann 2013: 1). They report that psychiatrists are more eager to include spiritual elements within care when spirituality plays a significant role within their personal lives and therefore recommend psychiatrists to possess self-awareness of spiritual beliefs.

The cultural backgrounds of clinicians may affect the level of attention to spiritual care. Dura-Vila, Hagger, Dein et al (2011: 53-60) explored the attitudes of psychiatrists in the UK towards spirituality and religion and discovered that migrant psychiatrists were found to censor their personal religious beliefs within their practice. They included spiritual beliefs during practice in their home countries but in the UK, they changed their practice to exclude spiritual assessment. The reasons were attributed to the fear of being judged as unscientific and unprofessional by medical colleagues and inadequate levels of support when discussing spiritual care information with clinicians. In contrast, El-Nimr, Green and Salib (2004: 165-169) examined mental health professionals' views of spirituality and found that non-UK respondents were more inclined than UK born respondents to acknowledge the spiritual component of mental health care which perhaps points towards the greater role of religion in other cultures. The provision of spiritual care may therefore be influenced by the cultural and religious background of mental health professionals.

The perspective of psychiatrists on spiritual care is divided. Contrary to the view that spirituality is fundamental to mental health care, Poole and Higgo (2011) argue that spiritual care is controversial and threatens the professional boundaries of therapeutic relationships with service users. Concern is expressed over Koenig's (2008) suggestions of conducting a spiritual history and praying with patients which is argued may cause harm to vulnerable people and demonstrate a lack of respect to those who are not affiliated with religious

beliefs. Similarly, in their study of German psychiatrists, Lee and Baumann (2013: 2-6) found that one of the barriers to spiritual care was the obligation to maintain professional boundaries and the intention not to influence patients by sharing personal beliefs. They report that 905 psychiatrists expressed the opinion that it is inappropriate to pray with patients. Cook, Powell and Sims et al (2011: 40) highlight the cultural differences between the United States which is more fundamentally religious than the United Kingdom, therefore suggesting that Koenig's recommendations for spiritual care may be perceived as more acceptable in the United States. In response to this debate, guidelines provided by the Royal College of Psychiatrists in the UK (RCPsych 2013) explicitly state that personal beliefs must not be expressed by psychiatrists in ways that can cause harm. The purpose of the guidelines is to promote good clinical practice to ensure that matters of spirituality and religion are addressed by psychiatrists with the awareness of ethical implications.

The current literature draws attention to not only the challenges of providing spiritual care but also the recommendations for best practice. A review of the literature on the impact of spirituality and mental health recommended that all service users should be asked about their spiritual needs throughout their care and helped to explore their spiritual issues (Cornah 2006). Koslander and Arvidsson (2005: 565) argue that a change of attitude towards the importance of spirituality is essential in mental health care. Spirituality should be recognised as a fundamental resource to enable the process of mental health recovery in which an individual can find meaning, hope and

strength in the experience of mental illness (Hodge 2004: 41-42, MHF 2008, Mohr 2011: 549, Suto and Smith 2014: 18). It is suggested that the first step in spiritual care is to listen to the individual and respect their spiritual and religious beliefs which involves taking a spiritual history (Chidarikere 2012: 300, D'Souza and George 2006: 410, Merchant, Gilbert and Moss 2008: 2, Ross 2006). It is argued that the NMC professional code should specifically make reference to spiritual needs which would provide nurses with stronger guidance on spiritual care (Ellis and Narayanasamy 2009: 888, McSherry and Ross 2017: 29).

Routine spiritual screening and undertaking a spiritual assessment are recommended to identify spiritual issues and to learn about the role of spiritual and religious beliefs (Chidarikere 2012:300, Gilbert 2008: 5, Healthcare Chaplaincy Network 2017: 10-11, Heffernan, Neil and Weatherhead 2014: Koenig 2012: 14, Mohr and Huguelet 2009). It is suggested that taking a spiritual history may have a therapeutic value by communicating to service users that the professional is interested in the whole person (D'Souza 2007, Moreira-Almeida, Koenig and Lucchetti 2014: 178). Several spiritual history tools exist to enable a detailed assessment, including the HOPE (Anandarajah and Hight 2001), SPIRIT (Maugans 1996) and FICA (Puchalski 2014, Puchalski and Romer 2000) tools which allow the professional to explore in depth the spiritual needs of the individual however, health care professionals may not have been trained to use the tools. Alternatively, Hodge (2013: 223-229) argues that spiritual assessment tools may not be effective for some service users who feel uncomfortable with spiritual language and suggests an

alternative approach to assessment. Spiritual or religious terminology may not fit with the individual's worldview therefore the approach avoids using such language. Instead an implicit spiritual assessment provides a means to develop a holistic understanding of the person when working with service users who do not identify themselves with spiritual language.

To meet the diverse spiritual needs of service users effectively, it is recommended that mental health professionals must work in partnership with other colleagues and community resources, including clergy to make referrals and to share expertise on spiritual and mental health issues (Cornah 2006, Guthrie and Stickley 2008: 399, Hefti 2011: 623, Mohr 2011: 552, Royal College of Psychiatrists 2010, Ross 2006: 853, Suto and Smith 2014: 24). A multidisciplinary team approach should involve discussion with the service user and family members to enable holistic care (Caldeira and Timmins 2017: 54-58). Eeles, Lowe and Wellman (2002: 197-205) suggest collaboration with other professionals is beneficial to minimise the risk of decision-making being informed by the idiosyncratic perspective of each professional discipline when considering the spiritual issues expressed in the context of the experience of mental illness.

This section has highlighted the key ideas in relation to the provision of spiritual care. Mental health professionals acknowledge the importance of spirituality in mental healthcare yet spiritual needs are neglected as a consequence of a series of interrelated barriers. Many nurses feel ill equipped

and lack the time and resources to include spiritual issues however, asking service users about their spiritual needs together with close working with other professionals and chaplaincy services is recommended which could improve treatment within spiritual care.

The current literature provides a picture of the ways in which spirituality has an impact upon mental health. The research in spirituality and mental health is rich and uses a diverse range of methodologies. Swinton (2007) highlights the importance of acknowledging the cultural differences between research from the US and the UK which may influence how the data is understood. What is perceived as culturally acceptable within the US may not be easily interpreted in the UK and vice versa. Research from the US predominantly focuses upon the function of religion which has an effect upon health (Koenig, King and Carson 2012) while UK research explores a broader perspective of spirituality. Previous literature reviews have focused upon spirituality in relation to the range of definitions and the language used within nursing (McSherry and Cash 2004, Reinart and Koenig 2013). Various aspects concerning the relationship between religion, spirituality and mental health care have been explored (Cornah 2006, Gearing, Alonzo and Smolak et al 2011, Goncalves, Lucchetti, Menezes et al 2015, Koenig 2009, Koenig 2012, Moreira-Almeida, Lotufo Neto and Koenig 2006, Pesut, Clark and Maxwell et al 2011, Snider and McPhedran 2014), while other literature reviews have been conducted to focus upon spiritual assessment and care provision (Heffernan, Neil and Weatherhead 2014, Elliot 2011, Moreira-Almeida, Koenig and

Lucchetti 2014, Mowat 2008, Ross 2006). Much of the research has focused upon quantitative evidence and whilst some studies have been carried out on the service user perspective of spirituality, there is very little qualitative analysis of the meaning of spirituality for mental health service users. Little is known about how spirituality is understood by service users which has the potential to inhibit the provision of spiritual care in mental health services. This indicates a need to understand the various experiences of spirituality that exist among mental health service users if mental health services are to be meaningful and improved.

Conclusions

This chapter has examined the importance of spirituality for mental health nursing. The role of spirituality in relevant policy frameworks has been explored. The themes within the current literature have included the debate around defining spirituality. The relationship between spirituality and mental health has been examined in relation to the range of positive and negative effects. Issues concerning the provision of spiritual care have been discussed. The current literature indicates a need for a shared understanding of spirituality between healthcare professionals and people experiencing mental health problems which points towards the systematic review question provided in the next chapter. The review question for this research is:

What does spirituality mean to people with mental health problems?

A detailed account of the systematic literature review process will be presented in chapter 2.

Chapter 2

A systematic literature review and qualitative analysis of the experience of spirituality and mental health from the perspective of people with mental health problems.

Chapter 1 provides a narrative review of the literature around spirituality and mental health, it highlights that it is important to consider spirituality in terms of mental health outcomes and mental health nursing practice. However, the experience of spirituality from the perspective of people with mental health problems is not well documented or summarised. In order to engage fully to care for individuals we need to better understand the value and meaning of spirituality to those with mental ill-health, from a variety of perspectives.

2.1 Objectives

The objectives of the review are identified below.

- To search for papers on the lived experience of patients with mental health problems in relation to spirituality.
- To compare the primary papers on the lived experiences of people with mental health problems to answer the following review question: ***What is the experience of spirituality for people with mental health problems?***

It is essential that the systematic review question and objectives are explicitly focused (Aveyard 2010: 19; Coughlan and Cronin 2017: 33). To construct a clear and focused qualitative question, the review question was framed using the Population, Exposure and Outcomes (PEO) framework (Bettany-Saltikov and McSherry 2016: 24). The components of the review question are illustrated below.

- **Population and their problem:** People with mental health problems
- **Exposure:** Spirituality and religion
- **Outcomes or themes:** Lived experiences of spirituality and mental health

2.2 Method

A systematic review was selected as the method to comprehensively search the relevant literature to answer a focussed question with minimal bias (Aveyard 2010: 19; Pettigrew and Roberts 2006: 9). The precise standardised process of systematic reviews informs the selection and appraisal of the studies which limits the bias of the review process and increases the quality of the findings (Coughlan and Cronin 2017: 29).

2.2.1 Scoping

Prior to undertaking the review, it was necessary to firstly determine if there were existing reviews on the topic which is recommended by the Centre for Reviews and Dissemination guidance (CRD) and guidance from the Joanna Briggs Institute (CRD 2009: 3; Lockwood, Porritt and Munn et al 2017). An

initial search for existing systematic literature reviews was therefore conducted using the following databases recommended by Bettany-Salticov and McSherry (2016: 34; CRD 2009: 3) which are listed in table 2.1.

Table 2.1 Searches for existing systematic reviews

Date searched	Database	Number of reviews
13.3.18	Evidence-Based Nursing (EBN) http://ebn.bmj.com	0
13.3.18	TRIP database www.tripdatabase.com	1 ongoing review
16.3.18	Evidence in Health and Social Care https://www.evidence.nhs.uk/	0
16.3.18	Centre for Reviews and Dissemination (CRD) www.york.ac.uk/crd/	0
16.3.18	Campbell Collaboration: www.campbellcollaboration.org	0
16.3.18	Cochrane Library www.thecochranelibrary.com	0
16.3.18	Cochrane Qualitative & Implementation Methods Group http://qim.cochrane.org/	0
16.3.18	UK Cochrane Centre: www.uk.cochrane.org	0
16.3.18	Cochrane Collaboration: http://www.cochrane.org/	0
16.3.18	Database of Abstracts and Reviews of Effects (DARE) www.community.cochrane.org	0
17.3.18	School of Health and Related Research (ScHARR) https://www.sheffield.ac.uk/scharr	0
17.3.18	Systematic Reviews Journal http://www.systematicreviewsjournal.com/	0
17.3.18	The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI Centre) http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=63	0
17.3.18	PROSPERO (http://www.crd.york.ac.uk/PROSPERO/) Open access international prospective register of systematic reviews in health and social care	0
17.3.18	The JBI database of systematic reviews and implementation reports http://joannabriggslibrary.org	0

The search identified one ongoing systematic review by Crawford, Slade and Edgley (2017) which explores the spiritual experiences of adults with mental health problems however the review was incomplete which provided justification for conducting this systematic review for the purpose of my research.

2.2.2 Inclusion and exclusion criteria

The development of explicit inclusion and exclusion criteria is essential for the identification of studies that specifically address the review question (Aveyard 2010: 71, Aveyard, Payne and Preston 2016: 76, Lockwood, Porritt and Munn et al 2017) and to clearly define the boundaries of the review (CRD 2009: 10-12). Lockwood, Porritt and Munn et al (2017) state that the characteristics of the selection criteria must demonstrate clear relevance to the review question therefore the inclusion and exclusion criteria were aligned with the review question using the components of the PEO framework. The criteria were set in the protocol before undertaking the review to minimise selection bias (Bettany-Saltikov and McSherry 2016: 42, Coughlan and Cronin 2017: 29). Table 2.2 provides details of the criteria which were used to specify eligibility for inclusion in the review.

Table 2.2 PEO template for inclusion and exclusion criteria

	Inclusion criteria	Exclusion criteria
Population People with mental health problems	People with experience of mental illness Any mental disorder Male or female adults aged 18-65 All types of mental health inpatient settings and community settings	Other patient groups Non mental health diagnosis Children and young people Older adults Mental health professionals Non mental health settings
Exposure Spirituality and religious experience	Spirituality and religion	Non spiritual/religious
Outcome Experience, perceptions, views, feelings, meaning	Experiences, perceptions, views from all members of the population group towards spirituality and religion.	No experience
Type of studies Qualitative	Phenomenological Grounded Theory Descriptive Ethnography	Letters Commentaries Reviews Discussion papers Quantitative studies

Table 2.2 identifies the details of the population to be studied which was male or female adults with mental health problems and specifies the age group of 18 to 65. The exposure of interest was spirituality and religion and the outcomes were defined as experiences of spirituality and religion. Bettany-Saltikov and McSherry (2016: 42, Lockwood, Porritt and Munn et al 2017) state the importance of capturing studies with the relevant research designs to address the review question therefore qualitative studies that explored the experience of spirituality and mental health were considered for selection.

2.2.3 Search strategy

The importance of appropriate keywords is essential for an effective literature search (Timmins and McCabe 2005: 44). MeSH terms were not included which is a potential limitation of the review. Bettany-Saltikov and McSherry (2016: 104) suggest using the components of the PEO framework for each part of the review question to develop the keywords and phrases using a number of stages. Table 2.3 illustrates the search terms and combinations which were constructed using the PEO framework and used to perform the literature search.

Table 2.3 Synonyms of keywords and phrases

Column terms combined with	Population AND	Exposure AND	Outcome AND	Type of study
OR	1.People with mental health problems 2.(Mental health patients or service users or clients) 3.(Mental health or mental illness or mental disorder or psychiatric illness) 4.Psychiatric patients or patients with psychiatric disorders) 5.Combine 1-4 using 'OR'	6.Spirituality 7.Religion 8.Spiritual care 9.Spiritual assessment 10.Spiritual interventions 11.Religiosity 12. Spiritual* 13. Religio* 14.Combine 6-13 using 'OR'	15.Experience 16.Meaning 17.(views or opinions or perceptions or beliefs or attitudes) 18.Understanding 19.Thoughts 20.Feelings 21.Combine 15-20 using 'OR'	22. Qualitative research 23. Interview 24. Focus group 25.Phenomenology 26. Grounded theory 27. Narrative 28. Combine 22-27 using 'OR'

The last step is to combine 5+14+21+28 together using the term 'AND'.

To generate the list of search terms, the first stage involved the identification of the keywords for each section of the review question. Secondly, the synonyms were identified for each section of the framework.

Aveyard, Payne and Preston (2016: 98) highlight the necessity of gathering as many synonyms as possible to maximise the opportunity of capturing relevant research which may use different key words. Thirdly the keywords were combined using the Boolean operators (OR, AND, NOT) to increase the specificity of the literature search. The final stage involved the identification of truncations to include variations of a word, for example 'religio*'. The numbers in the table indicate the order of how the keywords were typed into each database. Limitations were placed to English language articles only to increase the specificity of the search.

2.2.4 Databases searched

A combination of search approaches are recommended in order to gather the relevant literature and limit bias which included electronic and manual searches (Bettany-Saltikov and McSherry 2016: 113, CRD 2009: 160). The literature sources that were searched to access the relevant articles are described in this section. The first step involved using the search terms to search the electronic databases which are listed in table 2.4 within the results section. The table presents a record of the number of hits obtained and the number of articles that were retrieved from each database. The databases selected were those identified as commonly used for health research (Aveyard 2010: 75, Aveyard, Payne and Preston 2016: 72, Bettany-Saltivov and McSherry 2016: 113, Coughlan and Cronin 2017: 57, CRD 2009: 17), specifically Academic Search Complete (multidisciplinary), CINAHL, Nursing and Allied Health (nursing and allied health professionals), Medline and

PsycInfo (psychology and psychiatry), AMED (complementary medicine) and ASSIA (social sciences). The CRD (2009: 17, Lockwood, Porritt and Munn et al 2017) suggest that an extensive range of electronic databases should be accessed however, there is no indication of the number of databases that should be included. The maximum number of databases that were accessible were searched to increase the chances of locating studies relevant to the review. Lockwood, Poritt and Munn et al (2010) state that date limitations are applied when the review is focused upon a recent intervention, consequently the date ranges were unlimited for each database to avoid excluding early studies of potential importance.

2.2.5 Additional search strategies

The second step was to perform manual searches to identify studies which may not have been located through the electronic databases. A thorough search of additional literature sources is recommended to ensure a comprehensive strategy (Bettany-Saltikov and McSherry 2016: 113, CRD 2009: 17). Aveyard, Payne and Preston (2016: 83-83, Bettany-Saltikov and McSherry 2016: 113, Coughlan and Cronin 2017: 58-59, CRD 2009: 16) suggest common internet sites and approaches for the identification of unpublished research, known as grey literature which are listed below. Searches were performed by:

- Searching databases for grey literature using www.opengrey.eu, www.greynet.org
- Searching PhD theses databases using www.theses.com, EThOS and www.proquest.com

- Searching the National Institute for Health Research https://portal.nihr.ac.uk and the British Library http://www.bl.uk
- Searching subject gateways using Social Care Online: www.scie-socialcareonline.org.uk, National Library for Health: www.evidence.nhs.uk, www.nursing-portal.com and www.mentalhelp.net
- Relevant journals were identified and contents pages were manually searched which included the journals; 'Mental Health, Religion & Culture', 'Religions', 'Journal of Spirituality in Mental Health', 'Journal of Religion and Health', 'Journal of Mental Health'. The CRD (2009: 18) highlight the importance of this step as a means of locating recent research which may not yet have been indexed by electronic databases.
- Key authors in the field were identified and searches were performed using the author's name.
- Searching the reference lists of the included studies to identify additional relevant papers.

2.2.6 Study selection

This section presents the steps which formed the process of study selection. The CRD (2009: 23) suggest that the selection process should be clear, objective and transparent to reduce potential bias and error in order to ensure the inclusion of the relevant papers. The selection process consisted of two stages which is recommended by Bettany-Saltikov and McSherry (2016: 52, CRD 2009: 23). Stage 1 involved the decision to include or exclude each paper based on reading the title and abstract only. The decision was facilitated by

using a standardised form which was developed using the inclusion and exclusion criteria and therefore was directly related to the review question through the components of the PEO framework. Aveyard, Payne and Preston (2016: 90, Bettany-Saltikov and McSherry 2016: 121) state that the use of a selection form demonstrates evidence of the decision-making process which increases the truthfulness of the results. An example of the selection form is provided in Figure 2.1.

Figure 2.1 Standardised form for first selection of studies (based on title and abstracts)

Details of study Title: Authors: Source: Date of review:		
	Criteria	Yes/no/undecided
Participants	People with mental health problems? Adult patients?	
Exposure	Spirituality or religion?	
Outcome	Experience, perceptions or views?	
Type of study	Qualitative?	
Action (with rationale)	Include (read full article) or exclude?	

At this stage articles were included in the review if 'yes' or 'undecided' was the response to the selection questions however, studies were excluded if 'no' was indicated for any of the questions.

In the second stage of the selection process, the decision to include or exclude each study was based on reading the full text using a standardised form which was again based on the inclusion and exclusion criteria and informed by the PEO framework (Bettany-Saltikov and McSherry 2016: 121). An example of the form is presented below in figure 2.2.

Figure 2.2 Standardised form for second selection of studies (based on full text)

Details of study Title: Authors: Source: Date of review:		
	Criteria	Yes/no
Participants	People with mental health problems? Adult patients?	
Exposure	Spirituality or religion?	
Outcome	Experience, perceptions or views?	
Type of study	Qualitative?	
Action (with rationale)	Include (for full methodological analysis) or exclude?	

Studies were included in the review if all the questions were answered positively. Any negative responses resulted in the exclusion of the paper from the review.

2.2.7 Study appraisal

This section presents the methodological critiques of each selected paper which Lockwood, Porritt and Munn et al (2017) argue is essential for each study included in the review. The Critical Appraisal Skills Programme

(CASP 2018) tool for qualitative research was used to critique the quality of each study individually (see appendix 1 for an example of the CASP form). Bettany-Saltikov and McSherry (2016: 162) recommend assigning a numerical value to each question of the appraisal tool to facilitate the critique of the studies. The CASP tool consists of 10 questions and each question was assigned a score of either 0=No, 1=Partly or 2=Yes, resulting in a possible maximum score of 20.

2.3 Data Extraction and Synthesis

This stage of the review involved extracting the specific information from each study in order to answer the review question. Guidance from Aveyard, Payne and Preston (2016: 93-93, Bettany-Saltikov and McSherry 2016: 140, CRD 2009: 28-32) was used to develop the requirements of the data extraction form which grouped the study characteristics using the PEO framework in order to extract the relevant information for the review. An example of the data extraction form is provided in figure 2.3.

Figure 2.3: Data Extraction Form

The data extracted will be the words or perceptions of the population group.

Bibliographical Details of study:
Title:
Author:
Source:
Year:
Purpose of the study:
Study Design (Type of qualitative study):

Population
Sample size:
Age:
Ethnicity:
Religious groups:
Criteria of diagnosis:
Inclusion/Exclusion criteria:
Setting:

Exposure
Spirituality:
Religion:

Outcomes
Outcome: Patient's experience, views, perceptions of spirituality

Page	Data extracted	Subthemes

2.3.1 Synthesis

The themes were synthesised by searching for patterns and commonalities across the themes of the selected studies. The themes which frequently occurred were chosen as the most dominant themes.

2.4 Results

2.4.1 Study selection

Table 2.4 presents a record of the number of hits obtained and the number of articles that were retrieved from each database.

Table 2.4 The Electronic Databases

Database with dates	Search date	Number of hits retrieved from the search	Number of articles discarded because of irrelevant titles	Number of articles duplicated from another database	Number of articles to be retrieved by title and abstract
Academic Search Complete (1948-2018)	18.3.18	1662	1615	0	47
CINAHL (1986-2018)	20.3.18	826	797	16	13
MEDLINE (1971-2018)	20.3.18	574	563	10	1
PsycINFO (1985-2018)	21.3.18	1018	992	18	8
AMED (1998-2018)	21.3.18	48	45	2	1
ASSIA (1978-2018)	21.3.18	1081	1073	4	4
Nursing & Allied Health (1952-2018)	22.3.18	365	364	1	0

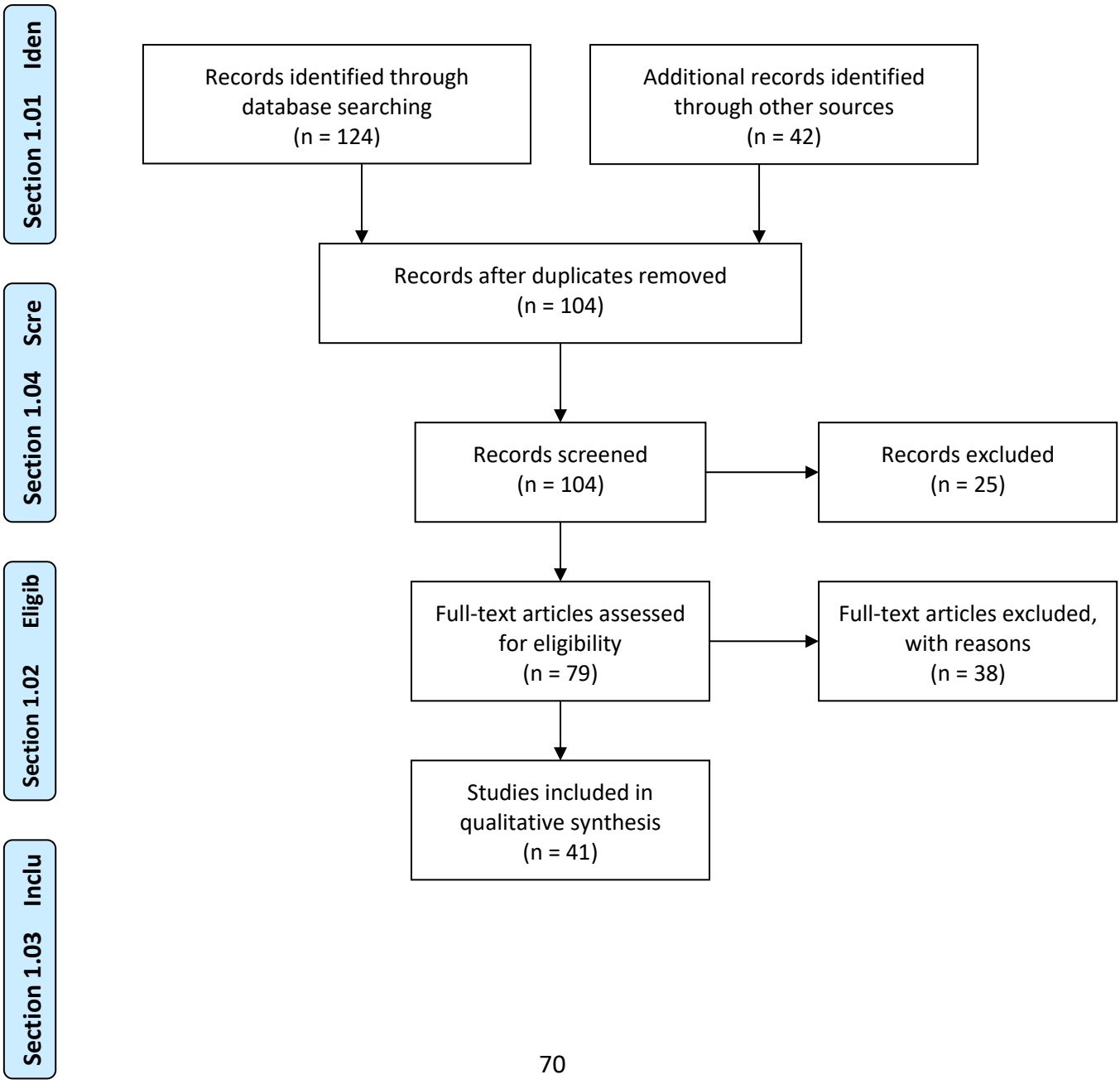
A total of 74 studies were retrieved from the first stage of the search. A total of 42 studies were identified from the manual search, of which 8 papers were duplicates which resulted in 30 studies to be retrieved. The combination of electronic and the manual searches found a total of 104 studies to be retrieved.

Table 2.5 which can be seen in appendix 2 presents a summary of the decisions made to include or exclude each article. The outcome of this selection stage resulted in the exclusion of 25 studies therefore, the total number of studies selected based on the title and abstract was 79. Table 2.6 which is in appendix 3 presents a summary of the decisions made in the second

stage of the selection process. The outcome of this stage resulted in the inclusion of 41 studies therefore 38 papers were excluded.

To ensure the transparency of reporting the search results, the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram is recommended (Aveyard, Payne and Preston 2016: 79, CRD 2009: 25, Moher, Liberati, Tetzlaff et al 2009) which is presented below in Figure 2.4. See appendix 4 for the PRISMA checklist.

Figure 2.4 PRISMA 2009 Flow Diagram



2.4.2 Characteristics of included studies

A variety of qualitative research designs were included in the findings of the review which are presented in table 2.7. Seventeen of these studies were of a phenomenological research design, of which five used hermeneutic theory and four used Interpretative Phenomenological Analysis (IPA). Eleven studies used a grounded theory approach. The remaining studies were conducted using a range of qualitative designs such as thematic analysis (four studies), one study used a descriptive approach, one content analysis, one ethnographic method and one narrative inquiry. Four of the studies did not disclose the qualitative approach which had been used.

In a phenomenological study Wilding, May and Muir-Cochrane (2005) found that spirituality sustained mental health. 6 adults who were receiving community mental health care in Australia were interviewed and expressed that spirituality supported them to cope with mental illness. Similarly, in a phenomenological study in Canada, Smith and Suto (2012) interviewed 9 participants who were living with schizophrenia and receiving community based care. The study identified that the participants used their spiritual and religious beliefs to cope with their mental illness. The relationship between spirituality and enhanced mental wellbeing was also evident in a grounded theory study in the UK in which it was found that religion played an influential role in the recovery from psychosis. Heffernan, Neil and Thomas et al (2016) explored the experiences of 10 participants with the experience of psychosis through semi-structured interviews and found that psychological wellbeing was enhanced with religion.

Spirituality was found to be a source of social support for people with serious mental illness. An ethnographic study which interviewed 40 adults with mental illness in the USA, found that the experience of social support from religious organisations enhanced mental wellbeing (Sullivan 1993). In addition, a grounded theory study in the USA which interviewed 30 women found religion provided support which caused people with mental illness to feel valued and less isolated (Keefe, Brownstein-Evans and Polmanteer 2016). This study differed in the research design and the specific focus upon mothers of a BME background with postnatal depression. These findings reflect the work of (Dein 2010: 28, Hadzic 2011: 226, Hodge 2004: 37, MHF 2006, Mohr 2006) who report that patients with mental illness find religion and spiritual beliefs supportive which enables coping with serious illness.

In an IPA study of 10 participants with mental health problems in Northern Ireland, Corry, Tracey and Lewis (2015) identified that spirituality enabled a connection with God which helped people in coping with mental illness. The importance of a relationship with God was also discovered in a phenomenological study of 17 participants with the experience of mental illness in Sweden. Lilja, DeMarinis, Lehti et al (2016) found that the relationship with God was perceived as one of importance as it generated feelings of support when facing mental illness but also created negative feelings of abandonment. This study differed as the focus was specific to people of a Christian faith. In comparison with other studies, these findings are consistent with the work of

Mohr and Huguelet (2004) who found that a close relationship with God enabled people to cope with the symptoms of psychosis.

One content analysis study in Geneva discovered a complex relationship between spirituality and mental illness which highlighted both positive and negative aspects of religion in coping with mental illness. Mohr, Brandt and Borras et al (2006) interviewed 115 outpatients with psychosis and discovered that for some patients, religion played a negative role through causing spiritual despair, increased symptoms of mental illness and greater social isolation. Similarly, a phenomenological study which interviewed 10 outpatients with bipolar disorder in the Netherlands found both positive and negative experiences of spirituality and religion. Some participants reported feeling religious doubt and the absence of God during depressive episodes.

Spirituality was found to be nuanced with personal meaning to individuals. One phenomenological study found that the experience of spirituality was unique to the person (Wilding, Muir-Cochrane and May 2006). This Australian research interviewed 6 people with mental illness and discovered spirituality became extremely important during mental illness. In a phenomenological study of 18 participants with serious mental illness in the USA, Starnino (2016) similarly identified that the experience of spirituality was personal and individualised. The sample included in this study were from a diverse range of ethnic backgrounds but the religious groups of the participants were not stated.

The research gathered was from fourteen different countries of which only eleven studies originated from the UK. Twelve studies were conducted in the USA and the remaining studies were of European origin and other countries which included Australia and Hong Kong. The ethnic groups varied between the studies however, twenty-four of these studies did not specify the ethnic groups of the sample. Only thirteen studies included people from a Black and Minority Ethnic (BME) background which suggests a need for more diverse participant groups.

A total number of 931 adults with mental health problems were included in the review, of which there were 303 men and 399 women however not all studies specified the gender of the participants. The studies that stated the ethnicity of the participants identified a total number of 253 people from a BME background. Only 2 of the 11 studies conducted in the UK included people from a BME population within the sample. The sample sizes were generally small which is a common feature of qualitative research, the smallest of which was 4 participants and the largest was 116 participants. The following table presents a summary of the included studies.

A summary of all the included studies is provided in Table 2.7 which is structured using the PEO framework.

Table 2.7 Summary of the included studies.

Study, Country of Origin	Population	Exposure	Outcome	Results
1: Heffernan, S., Neil, S.,Thomas, Y., & Weatherhead, S. (2016) 'Religion in the recovery journey of individuals with experience of psychosis'. *Psychosis*, 8 (4), 346-356 UK	10 mental health patients, aged between 25 and 35, 8 men and 2 women.	The experience of religion and recovery from psychosis.	Gain an insight into the experiences of people with mental health problems to explore how religion may influence recovery.	Eight main themes emerged; use of scriptures and rituals, a genuine connection with God, the struggle to maintain rituals, guidelines for living, choice and control, relating to others, enhancing psychological well-being and making sense of experiences.
2: Ho, R.T.H., Chan, C,K.P., Lo, P.H.Y., Wong, P.H., Chan, C.L.W. Leung, P.P.Y., & Chen, E.Y.H. (2016) 'Understandings of spirituality and its role in illness recovery in persons with schizophrenia and mental health professionals: a qualitative study'. *BMC Psychiatry* 16 (86), 3-11 Hong Kong	18 mental health patients, aged 18-38.	The meaning and role of spirituality.	An understanding of the experience of spirituality from the perspective of people with schizophrenia.	Two main themes and seven subthemes emerged; Personal domain, sense of self, philosophy of life, growth after the acute phase of an illness and peacefulness. Communal domain; religion, interpersonal relationships and apparitional experiences.
3: Smith, S., & Suto, M.J. (2012) 'Religious and/or spiritual practices: Extending spiritual freedom to people with schizophrenia'. *Canadian Journal of Occupational Therapy* 79 (2), 77-85 Canada	9 mental health patients, aged 39-59.	The meaning of religion and spirituality for people living with schizophrenia.	An insight into the meaning of religion and spirituality.	Two main themes emerged; Religious/spiritual practices: Doing to nurture spirituality, Religious/Spiritual agency: Freedom to think in spiritual terms.
4: Bhui, K., King, M., Dein, S., & O'Connor, W. (2008) 'Ethnicity and religious coping with mental distress'. *Journal of Mental Health*, 17(2), 141-151 UK	116 people with common mental disorder, aged 25-50, 49 men and 67 women.	The experience of religious coping with mental distress.	Gain an insight into the experiences of religion and mental health.	Two main themes emerged; Components of religious coping and Religious explanations for symptoms of distress.
5: Wilding, C., Muir-Cochrane, E., & May, E. (2006) 'Treading lightly: Spirituality issues in mental health nursing'. *International Journal of Mental Health Nursing*, 15, 144-152 Australia	6 people with mental illness, aged 40-60, 3 men and 3 women.	The experience of spirituality.	An insight into the meaning of spirituality for people with a mental illness.	Five main themes emerged; Spirituality is unique, Spirituality is a lifelong journey, Mental illness: Call to spiritual life, Desire to share spirituality with others, Difficulties discussing spirituality with mental health professionals.

Study, Country of Origin	Population	Exposure	Outcome	Results
6: Ouwehand, E., Muthert, H., Zock, H., Boeije, H., & Braam, A. (2018) 'Sweet Delight and Endless Night: A Qualitative Exploration of Ordinary and Extraordinary Religious and Spiritual Experiences in Bipolar Disorder'. *The International Journal for the Psychology of Religion* 28 (1), 31-54 **The Netherlands**	35 people with Bipolar disorder, aged 23-69, 18 men and 17 women	The experience of religion and spirituality during mania.	Gain an insight into the religious and spiritual experiences of bipolar disorder patients.	23 main themes emerged; Transendental reality, Mission or Vocation, Meaningful synchronicity, Other positively valued experiences, Negatively valued experiences, Pos/neg emotion, Fusion, Physical sensations, Energy/power, Intensity, Altered awareness, Absence, Guilt and punishment, Religious doubt, Presence of evil, Trust and confidence, Suicidality, Fear, Sliding scale, No religious experiences, Ordinary religious or spiritual experiences, Clear distinction, Regular paranormal experiences.
7: Corry, D.A.S., Tracey. A.P., & Lewis, C.A. (2015) 'Spirituality and Creativity in Coping, Their Association and Transformative Effect: A Qualitative Enquiry'. *Religions* 6, 499-526 **Northern Ireland**	10 people who have experienced mental health problems, aged 29-70, 5 men and 5 women.	The experience of creativity and spirituality in coping.	Insight into the experiences of spirituality in coping with mental illness.	Two main themes and 14 subthemes emerged; Coping through a spiritual attitude/way of life. Spirituality is distinct from religion, Spirituality fosters connectedness to God, self, and others, Spirituality helps combat depression and addiction, Spirituality gives perspective, Spirituality gives hope, Spirituality provides meaning, Spirituality provides guidance and protection. Coping through creative expression; creativity is an aspect of spirituality, creativity alleviates anxiety, creativity facilitates sharing and connecting, creativity provides focus, creativity gives joy, creativity provides meaning, creativity provides self-esteem.
8: Carlisle, P.A. (2015) '"We don't Talk about that Around Here.": religion, spirituality and mental health in Northern Ireland'. *Mental Health, Religion and Culture* 18 (5), 396-407 **Northern Ireland**	12 mental health service users, aged 48-73	The experience of mental health problems and the role of religion and spirituality.	Understand the voice of mental health service users regarding religion and spirituality.	Three main themes and 7 subthemes emerged; Religion, spirituality and identity, role of spirituality within mental health. Religion, spirituality and mental health service provision; Mental Health professional's job remit, How might disclosure be viewed?, Keeping silent: spirituality and privacy. The wider social context; Perceptions of "normal" and "excessive" expressions of spirituality, The legacy of the conflict -we don't talk about religion around here.

Study, Country of Origin	Population	Exposure	Outcome	Results
9: Yang, C.T., Narayanasamy, A., & Chang, S.L. (2011) 'Transcultural spirituality: the spiritual journey of hospitalised patients with schizophrenia in Taiwan'. *Journal of Advanced Nursing* 68 (2), 358-367 Taiwan	22 mental health patients with schizophrenia, aged 29-63, 10 men and 12 women.	The experience of spirituality.	Gain an insight into the experience of spirituality and schizophrenia.	Two main themes and 9 subthemes emerged; I am not a normal person: spiritualty distressed, Taiwanese/Chinese ideology, Limited autonomy, self-actualisation and dignity, Disconnection with or estrangement from the family, Feelings of rejection and stigmatisation, The end of the road: a sense of meaningless and hopelessness. I want my life back and I want to regain my spirituality, Revealing the self/proving self efficacy, Sources of support, The self as a resource, Changing thoughts and thanksgiving.
10: Chan, C.K.P., & Ho, R.T.H. (2017) 'Discrepancy in spirituality among patients with schizophrenia and family care-givers and its impacts on illness recovery: A Dyadic Investigation'. *British Journal of Social Work*, 47, 28-47 Hong Kong	8 mental health patients with schizophrenia, mean age of 27, 7 men and 1 woman.	The experience of spirituality.	Explore the meaning and role of spirituality in recovery for patients with schizophrenia.	Four main themes and five subthemes emerged; Similarities in the understanding of spirituality; seeking inner peace, way of thinking, belief and values towards life, self-understanding. Differences in the understanding of spirituality; different belief systems. Family dynamics when differences existed. Impact on patients' recovery.
11: Starnino, V.R. (2014) 'Strategies for Incorporating Spirituality as Part of Recovery-Oriented Practice: Highlighting the Voices of Those With a Lived Experience'. *Families in Society: The Journal of Contemporary Social Services*, 95 (2), 122-130 USA	18 people with serious mental illness, aged 20-62, 6 men and 12 women	The experience of spirituality.	Gain an insight into the experience of spirituality as part of recovery.	Four main themes and 6 subthemes emerged; Effective listening. Directive strategies; Offering spirituality related advice, Participating in a healing ceremony with a client. Strategies for Addressing the Intersection Between Spirituality and Illness; Do not assume pathology; use a nonconfrontational approach, Explore coping strategies. Strategies Related to Involvement in Spiritual Communities; Facilitating community supports, Direct collaboration with a spiritual leader, Discussing difficult spiritual issues.
12: Salimena, A.M., Ferrugini, R.R.B., Melo, M.C.S.C, & Amorim, T.V. (2016) 'Understanding spirituality from the perspective of patients with mental disorders: contributions to nursing care'. *Revista Gaucha de Enfermagem* 37 (3), 1-7 Brazil	9 people with any form of mental disorder, aged 35-64.	The meaning of spirituality.	Gain an understanding into the meaning of spirituality.	Two main themes emerged; Spirituality is a therapeutic support for mental health. The temple is the religious manifestation of spirituality.

Study, Country of Origin	Population	Exposure	Outcome	Results
13: Sreevani, R., & Reddemma, K. (2012) 'Depression and spirituality – A qualitative approach'. *International Journal of Nursing Education* 4 (1), 90-93 India	8 mental health patients with depression, aged 20s-40s, 2 men and 6 women.	The experience of spirituality.	Gain an insight into the experience of spirituality and depression.	Seven main themes emerged; Statements about understanding of depression, Understanding of Spirituality, Statements of how spirituality helps to deal with depression, Statements regarding depression impact on spirituality, Statements about common spiritual activities followed during the episode, Statements regarding help from religious organisations, Participants statements: viewpoints on how healthcare providers can help the patient deal with depression using spirituality.
14: Mohr, S., Brandt, P-Y., Borras, L., Gillieron, C., & Huguelet, P. (2006) 'Toward an Integration of Spirituality and Religiousness Into the Psychosocial Dimension of Schizophrenia'. *American Journal of Psychiatry* 163 (11), 1952-1959 Switzerland	115 mental health patients with schizophrenia, mean age 39, 80 men 35 women.	The experience of the role of religion.	Gain an insight into the negative and positive roles of religion in coping with psychosis.	Two main themes emerged; Positive effects of religious coping and Negative effects of religious coping.
15: Al-Solaim, L., & Loewenthal, M. (2011) 'Religion and obsessive-compulsive disorder (OCD) among young Muslim women in Saudi Arabia'. *Mental Health, Religion and Culture* 14 (2), 169-182 Saudi Arabia	15 Muslim women with OCD.	The experience of religion and OCD.	Gain an insight into the role of religion in the experience of OCD.	Eight main themes emerged; Help-seeking behaviour, Perception of causality of obsessional symptoms, The importance of religiosity and religious knowledge in mental health professionals, Symptoms in the religious domain are more disturbing than in other domains, The most prevalent symptoms were related to daily prayers, Role of religion in coping with symptoms, Religion and self-esteem, Going through a period of religious extremism while experiencing OCD.
16: Hustoft, H., Hestad, K.A., Lien, L., Moller, P, & Danbolt, L.J. (2013) '"If I Didn't Have My Faith I Would Have Killed Myself!": Spiritual Coping in Patients Suffering From Schizophrenia'. *The International Journal for the Psychology of Religion* 23, 126-144 Norway	12 people with schizophrenia, aged 18-68.	The experience of spiritual coping.	Gain an insight into the experience of spiritual coping and schizophrenia.	Six main themes emerged; Spirituality to be a support however, diagnosed as religious delusions, Spirituality, hallucinations and delusional systems were closely woven together, The experience of having supernatural powers, Experiences of being controlled by evil forces, Spiritual struggle, A private belief system of being Jesus does not interfere with treatment compliance.

Study, Country of Origin	Population	Exposure	Outcome	Results
17: Green, J.E., Gardner, F.M., & Kippen, S.A. (2009) 'Healing of the Soul: The Role of Spirituality in Recovery from Mental Illness'. *The International Journal of Psychosocial Rehabilitation* 13 (2), 65-75 **Australia**	6 people with experience of mental illness, aged 31-58, 3 men and 3 women.	The experience of spirituality and recovery.	Gain an insight into the role of spirituality in recovery from mental illness.	Four main themes emerged; Personal concepts of spirituality, Relationship to religious experience, Spirituality and developing a sense of recovery, What supported spirituality.
18: Wilding, C., May, E., & Muir-Cochrane, E. (2005) 'Experience of spirituality, mental illness and occupation: A life-sustaining phenomenon'. *Australian Occupational Therapy Journal* 52, 2-9 **Australia**	6 mental health community patients, aged 35-55, 3 men and 3 women.	The experience of spirituality.	Gain an insight into the experiences and meanings of spirituality and the experience of mental illness.	Three main themes emerged; Spirituality as life-sustaining, Spirituality saves one from death, Spirituality sustains occupation, Spirituality sustains mental health and well-being.
19: Starnino, V.R., & Canda, E.R. (2014) 'The Spiritual Developmental Process for People in Recovery from Severe Mental Illness'. *Journal of Religion and Spirituality in Social Work* 33, 274-299 **USA**	18 mental health patients with serious mental illness, aged 20-62, 6 men and 18 women.	The lived experience of spirituality.	Gain an insight into the experiences of spirituality and recovery.	Four main themes and 16 subthemes emerged; Basic impact, experience benefits from spirituality but no high impact on recovery, spiritual benefits associated with temporary effect, difficulty working through spiritual struggles, no clear sense of meaning or purpose. Symptoms as a barrier; spirituality plays important role but intersects with symptoms, spiritual benefits associated with whole person change, intersection of spirituality and illness, life has a meaning and purpose. In progress; move forward in spirituality and recovery, spiritual beliefs associated with whole person shift, ability to work through spiritual struggles. High Synergy; Able to renew spirituality, work through struggles, sense of meaning and purpose.
20: Macmin, L., & Foskett, J. (2004) ' "Don't be afraid to tell." The spiritual and religious experience of mental health service users in Somerset'. *Mental Health, Religion and Culture* 7 (1), 23-40 **UK**	27 mental health service users, aged 20-70, 10 men and 17 women.	The experience of spirituality and religion.	Gain an insight into the experiences of spirituality and religion of mental health service users.	Four main themes emerged; To talk or not to talk, What is the talking for, The search for meaning, Transformation.

Study, Country of Origin	Population	Exposure	Outcome	Results
21: Young D. (2015) 'Positive effects of spirituality in facilitating recovery for people with severe mental illness'. *International Journal of Psychosocial Rehabilitation* 19 (1), 1-11 Hong Kong	6 people with mental illness, aged 23-44, 1 man and 5 women.	The experience of spirituality and recovery.	Gain an insight into the experiences of the positive impacts of spirituality on mental illness.	Seven main themes emerged; Profound sense of loss, Spiritual elements in facilitating mental health recover, Providing positive meaning towards the onset and relapse of mental illness, Inducing hope for recovery from mental illness, Forgiving those who have hurt them during the onset or relapse of mental illness, Using spiritual coping skills to reduce psychiatric symptoms, Offering social support.
22: Keefe, R.H., Brownstein-Evans, C., & Polmanteer, R.R. (2016) ' "I find peace there": how faith, church, and spirituality help mothers of colour cope with postpartum depression'. *Mental Health, Religion and Culture* 19 (7), 722-733 USA	30 mothers with symptoms of postpartum depression, aged 18-44.	The experience of spirituality and religion.	Gain an insight into the experiences of spiritual practices and coping with mental illness.	Six main themes emerged; Relief from stress, Feeling valued and less alone, Experiencing gratitude, Developing perspective and accepting god's guidance, Changing and developing relationships, Preventing self-harm.
23: Raffay, J., Wood, E., & Todd, A. (2016) 'Service user views of spiritual and pastoral care (chaplaincy) in NHS mental health services: a co-produced constructivist grounded theory investigation'. *BMC Psychiatry* 16 (200), 1-11 UK	22 mental health service users, aged 40-60+, 17 men and 5 women.	The experience of spiritual care.	Gain an insight into the experiences of spiritual care.	Five main themes emerged; The meaning of spiritual care, The benefits of the spiritual and pastoral care department, The role of religion, Qualities of a 'good' chaplain – Who talks to chaplains and when, Chaplains and the multidisciplinary team.
24: Nabil, A., Saini, S.M., Nasrin, N., Bahari, R., & Sharip, S. (2016) ' 'I can't pray' – The spiritual needs of Malaysian Muslim patients suffering from depression.' *International Medical Journal Malaysia* 15 (1), 103-109 Malaysia	10 Muslim mental health patients with depression, aged 28-65, 5 men and 5 women	The experience of spiritual needs.	Gain an insight into the experiences of spirituality and depression.	Two main themes and 11 subthemes emerged; Religious needs, Knowledge and guidance, worship, reminders. Existential needs; calmness, physical help, certainty, hope, sensitivity and empathy, self-discipline, ventilate, meaning of illness.
25: Eltaiba, N., & Harries, M. (2015) 'Reflections on Recovery in Mental Health: Perspectives From a Muslim Culture'. *Social Work in Health Care* 54, 725-737 Israel	20 Muslim mental health patients, aged 24-25, 10 men and 10 women.	The experience of religion and mental illness.	Gain an insight into the experiences of religion and recovery.	Four main themes emerged; Centrality of religion in participants' reflections on recovery, Causation and the link to coping and recovery, Recovery as a dynamic process, Barriers to recovery.

Study, Country of Origin	Population	Exposure	Outcome	Results
26: Laird, L.D., Curtis, C.E., & Morgan J.R. (2016) 'Finding spirits in spirituality: What are we measuring in spirituality and health research?' *Journal of Religion and Health* 56, 1-20 USA	13 women with depression.	The experience of spirituality and religion.	Gain an insight into the experiences of spiritual and religious practices in relation to coping.	Three main themes emerged; Asking about spirituality – fluidity of the terms religious and spiritual, God's role in leading or guiding the individual in relation to both stress and peace, Spirits in spirituality.
27: Starnino, V.R. (2016) 'Conceptualising Spirituality and Religion for Mental Health Practice: Perspectives of Consumers With Serious Mental Illness'. *Families in Society: The Journal of Contemporary Social Services* 97 (4), 295-304 USA	18 mental health patients with serious mental illness, aged 20-62, 6 men and 12 women.	The experience of spirituality.	Gain an insight into the experiences of spirituality and recovery for people with serious mental illness.	Three main themes emerged; No label, Primarily religious, Spiritual-But-Not-Religious.
28: Moller, M.D. (1999) 'Meeting Spiritual Needs on an Inpatient Unit'. *Journal of Psychosocial Nursing and Mental Health Services* 37 (11), 5-10 USA	65 mental health patients, aged 19-81.	The meaning of spirituality and religion.	Gain an insight into the experiences of spirituality and religion.	Four main themes emerged; Is there a difference between religion and spirituality for you?, The experience of psychosis from a spiritual perspective, Attempts by Pastoral Services/Clergy/Spiritual Advisor to Bring Comfort, Themes of Spiritual Needs: Comfort, Companionship, Conversation, Consolation.
29: Sullivan, W.P. (1993) ' "It Helps Me to Be a Whole Person": The Role of Spirituality Among the Mentally Challenged'. *Psychosocial Rehabilitation Journal* 16 (3), 125-134 USA	40 people with experience of mental illness, aged 35-43.	The role of spirituality in the experience of mental illness.	Gain an insight into the importance of spirituality.	Three main themes emerged; Spirituality as a coping or problem-solving device, Spirituality and social support, Spiritual explanation and well-being.
30: Carlisle, P. (2015) 'A Tricky Question: Spirituality and Mental Health Social Work Practice in Northern Ireland'. *Journal of Religion and Spirituality in Social Work* 34, 117-139 Northern Ireland	12 mental health service users.	The lived experience of spirituality.	Gain an insight into the ambivalence around spirituality.	Three main themes emerged; Individual meaning making, Service Provision, Wider Social Field.

Study, Country of Origin	Population	Exposure	Outcome	Results
31: Sorajjakool, S., Aja, V., Chilson, B., Ramirez-Johnson, J., & Earll, A. (2008) 'Disconnection, Depression and Spirituality: A Study of the Role of Spirituality and Meaning in the Lives of Individuals with Severe Depression'. *Pastoral Psychology* 56, 521-532 **USA**	15 people with depression, 3 men and 12 women.	The meaning of spirituality.	Gain an insight into the role and meaning of spirituality for people with depression.	Three main themes and 5 subthemes emerged; Spirituality, defining spirituality, Impacts of depression on spirituality, Impacts of spirituality on depression. Meaning. Acceptance, Acceptance of life circumstances, Acceptance of depression.
32: Russinova, Z., & Cash, D. (2007) 'Personal Perspectives about the Meaning of Religion and Spirituality among Persons with Serious Mental Illnesses'. *Psychiatric Rehabilitation Journal* 30 (4), 271-284 **USA**	40 people with serious mental illness, aged 28-67, 16 men, 24 women.	The meaning of spirituality and religion.	Gain an insight into the meanings attributed to religion and spirituality.	Two main themes and 28 subthemes emerged; Understanding the concept of religion – organised character, communal character, ritualistic character, doctrinal character, dogmatic/prescriptive character, extrinsic character, man-made nature, functional characteristics of religion – supportive/comforting character, judgemental character, disempowering character, fear-inducing character, socially divisive character, socially acceptable character. Understanding of the concept of spirituality, core characteristics of spirituality – Informal character, personal character, intrinsic character, exploratory character, personal relationship with the transcendent, awareness of one's own soul, awareness of universe life force, sense of universal connectedness, continuous character, functional characteristics of spirituality – compassion and acceptance of others, meaning finding, empowering character, promoting harmony and balance, letting go of control, promoting healing.
33: Drinnan, A., & Lavender, T. (2006) 'Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions'. *Mental Health, Religion and Culture* 9 (4), 317-331 **UK**	7 community mental health patients with experience of delusions, aged 30-53, 6 men and 1 woman.	The experience of religious beliefs and delusions.	Gain an insight into the experiences of religious beliefs and delusions.	Three main themes and five subthemes emerged; Social context and triggers for psychological difficulties, family, relationships. Personal – identity development, Religious-identity development, positive aspects of religion, negative aspects of religion, unusual religious beliefs. Negotiating identity.

Study, Country of Origin	Population	Exposure	Outcome	Results
34: Ouwehand, E., Wong, K., Boeije, H., & Braam, A. (2014) 'Revelation, delusion or disillusion: subjective interpretation or religious and spiritual experiences in bipolar disorder'. *Mental Health, Religion and* Culture 17 (6), 615-628 The Netherlands	10 mental health outpatients with Biploar disorder, average age 45.	Spiritual and religious experiences.	Gain an insight into the religious and spiritual experiences during mania, depression and recovery.	Six main themes and 14 subthemes emerged; Depressive episode, support, absence/abandonment by God, Failure, guilt, punishment, Devil, dark powers, suicide, religious doubt. Manic episode, vocation, paranormal experience, vision, connection, presence God/Light, Fusion, Mystical union, Time, Deepest self. The quest for meaning and the authenticity of the experiences. Cherishing of blissful experience. Spiritual practice as support in illness-management. Expectations for treatment.
35: Koslander, T., & Arvidsson, B. (2007) 'Patients' conceptions of how the spiritual dimension is addressed in mental health care: a qualitative study'. *Journal of Advanced Nursing* 57 (6), 597-604 Sweden	12 mental health patients, aged 20-59.	The experience of spiritual needs in mental health care.	Gain an insight into the experiences of spiritual needs in mental health care.	Four main themes and 7 subthemes emerged; Patients wish to have their spiritual needs addressed, patients actively seek the assistance of nurses, It is the nurses' task to address spiritual needs. Patients must see to it that their spiritual needs are addressed, patients seek professional external help, patients turned inwards and provide for their own spirituality, patients interact with other patients who provide for their spiritual needs. Patients lack confidence in nurses with regard to discussing spirituality, Nurses avoid addressing patients' spiritual needs, Nurses lack knowledge about the spiritual dimension.
36: Greasley, P. Chiu L.F., & Gartland, M. (2001) 'The concept of spiritual care in mental health nursing'. *Journal of Advanced Nursing* 33 (5), 629-637 UK	9 focus groups, 4-6 people in each group, mental health service users.	The experience of spiritual care.	Gain an insight into the experiences of spiritual care.	Two main themes and 1 subtheme emerged; The concept of spirituality, Is there a difference between spiritual care needs and religious care needs? Spirituality and health.
37: Lilja, A., DeMarinis V., Lehti, A, & Forssen, A. (2016) 'Experiences and explanations of mental ill health in a group of devout Christians from the ethnic majority population in secular Sweden: a qualitative study'. *BMJ* Open 6, 1-9 Sweden	17 people of Swedish background with experience of mental ill health, aged 30-73, 5 men and 12 women.	The experience of mental ill health and Christianity.	Gain an insight into the meaning of Christianity for people with mental illness.	Three main themes and 8 subthemes emerged. Relationship with God; importance of the relationship, asymmetries in the relationship, movements in the relationship. Symptoms and existential meaning; usual symptoms and their existential meaning, existential consequences. Explanations of illness; biopsychosocial explanations, existential explanations, duplicate explanation-consonance and dissonance.

Study, Country of Origin	Population	Exposure	Outcome	Results
38: Marsden, P., Karagianni, E., & Morgan, J.F. (2007) 'Spirituality and Clinical Care in Eating Disorders: A Qualitative Study'. *International Journal of Eating Disorders* 40, 7-12 UK	10 females, aged 18-56.	The relationship between eating disorders and religion.	Gain an insight into the experiences of eating disorders and religion.	Five main themes emerged. Locus of control, Self-Image, Sacrifice, Salvation, Maturation.
39: Starnino, V.R., & Sullivan, W.P. (2016) 'Early trauma and serious mental illness: what role does spirituality play?' *Mental Health, Religion and Culture* 19 (10), 1094-1117 USA	18 people with SMI, 12 women, 6 men.	The relationship between early trauma and spirituality.	Gain an insight into the experiences of spirituality, religion, early trauma and serious mental illness.	Five main themes emerged. Early trauma and impact, Psychological crisis, Spiritual crisis, Spiritual turning point(s) and rebuilding, Recovery/posttraumatic growth.
40: Whiteley, C., Coyle, A., & Gleeson, K. (2017) 'An idiographic analysis of women's accounts of living with mental health conditions in Haredi Jewish communities'. *Mental Health, Religion and Culture* 20 (3), 277-293 UK	4 women with experience of mental health difficulties, aged 25-29.	The lived experience of women who developed mental health conditions while living in Haredi Jewish communities.	Gain an insight into the experiences of mental illness and the response from the religious community.	Three main themes and six subthemes emerged. The negative evaluation of mental health conditions in Haredi communities; Mental health difficulties as individual failure: stigmatisation by Haredi communities and self, Mental Health difficulties as fracturing the moral order. "Cloak and dagger": secrecy and consequences of mental health problems in Haredi communities; Secrecy and the inexpressibility of mental health difficulties, Mental health difficulties as undermining marriage prospects. Going and staying: mental health experiences and changed relationships with Haredism/Judaism; A considered exit from Haredism, A reconsidered and revised engagement with Haredism.
41: Prout, T.A., Ottaviano, P., Taveras, A., Sepulveda, C., & Torres, J. (2016) 'Parental and God Representations Among Individuals with Psychosis: A Grounded Theory Analysis'. *Journal of Religion and Health* 55, 2141-2153 USA	46 people with schizophrenia or other psychotic disorder, aged 21-71, 18 men and 28 women.	The experience of religion and psychosis.	Gain an insight into the experiences of religion and psychosis.	Six main themes emerged. Representation of Mother, Father, and God; Caregiver Love and Nurturance, Need for or Belief in God, Death or Illness of Family, Gratitude and Love for God, Parents provided concrete support, Tolerating ambivalence.

2.4.3 The quality of the included studies

The methodological quality of the studies varied which was indicated by the rating of each study using the CASP framework. The study by Ho, Chan, Lo et al (2016) was of excellent quality scoring 20/20. Nine studies scored 17-19 which pointed towards their high quality. Credibility was increased in studies in which the relationship between the researcher and participants was considered. Clancy (2013: 13-15) suggests the importance of considering the position of the researcher to highlight the potential influence on the findings. In the study by Ho, Chan, Lo et al (2016), it was evident that the researcher's role was examined by the discussion of the interview questions with the research team to minimise the potential bias during the development of the research questions. Corry, Tracey and Lewis (2015), Heffernan, Neil and Thomas (2016) and Wilding, Muir-Cochrane and May (2006) acknowledged the position of the interviewer in their studies in relation to the interviewer's personal beliefs, experience and background which may have had a potential impact upon interviews. The role of the researcher was also considered in the study by Carlisle (2015) in which the researcher used a diary to critically reflect upon personal thinking, biases and spiritual beliefs.

Credibility was strengthened in the data analysis by utilising peer debriefing. In 24 of the studies more than one analyst was involved to review the themes of the data analysis which included other researchers, research teams and supervisors. In the studies by Starnino (2016), Starnino and Canda (2014) and Starnino and Sullivan (2016) a panel was consulted for feedback on

the analysis in addition to the involvement of peers. Credibility was also enhanced in 8 studies which carried out member checking which is a technique in which the participants provide feedback on the responses (Silverman 2006). In the studies by Macmin and Foskett (2004) and Ouwehand, Wong, Boeije et al (2014) the transcripts were checked with the participants to confirm the responses. Other papers presented the participants with the themes from the findings in order to receive feedback on the analysis (Green, Gardner and Kippen 2009, Nabil, Saini, Nasrin et al 2016) and in the study by Sreevani and Reddemma (2012), feedback interviews were held with 8 participants to enhance credibility of the findings. Triangulation is a method which involves gathering different perspectives to increase understanding (Yardley 2015: 261) and was used by some studies whereby feedback on the findings was sought from both the participants and peers which indicates enhanced credibility.

The ethical considerations of the included studies were significant given the vulnerability of the participants and the process of interviewing this population group about a sensitive topic. Finlay (2011: 190) highlights that research can touch on evocative personal issues therefore due care and a respectful approach are essential requirements of researchers. The study by Ho, Chan, Lo et al (2016) asked all participants to provide their written informed consent after the study's purpose and procedures were explained to them. Confidentiality was maintained with the issue of participant identification codes and the assurance that personal data and identity would remain anonymous. Ethical issues were clearly considered in the paper by Koslander and Arvidsson

(2007) in which written information was provided for participants. Confidentiality was discussed and participants were informed both in writing and orally that their participation was voluntary and they were free to withdraw at any time.

A large number of studies were rated as poor quality with 18 papers scoring below 14/20. In relation to the ethical aspects of the included studies, 9 papers did not mention the consideration of ethical issues or the receipt of ethical approval. Other studies stated that ethical approval had been sought however, minimal details were provided of confidentiality issues and the process of informed consent.

The outcomes of some of the studies may have been compromised by the introduction of potential bias through numerous means. The relationship between the researcher and the participants was not addressed in 26 of the studies which suggests that bias may have been introduced during the data collection and analysis. In the papers by Ouwehand, Muthert, Zock et al (2018), Ouwehand, Wong, Boeije et al (2014) and Raffay, Wood and Todd (2016) the interviewers were known to the participants which could have influenced the responses of the participants whereby accounts were provided which were favourable to the researchers. In relation to data collection methods, most papers utilised face-to face in depth semi-structured interviews for data collection which were audio-recorded and transcribed, with the exception of 2 studies by Greasley, Chiu and Gartland (2001) and Moller (1999). These

papers carried out focus groups which may have constrained individual responses about personal experience in order to conform with the group.

A total score was provided for the overall quality of each study of which a detailed breakdown is presented in appendix 5 in table 2.8. Below in table 2.9 is a simplified presentation of the overall quality score of each study.

Table 2.9 The overall quality score for each study.

Study	Quality Score		Study	Quality Score
1	17/20		**23**	14/20
2	20/20		**24**	13/20
3	19/20		**25**	7/20
4	17/20		**26**	9/20
5	17/20		**27**	10/20
6	18/20		**28**	10/20
7	16/20		**29**	9/20
8	17/20		**30**	13/20
9	16/20		**31**	13/20
10	17/20		**32**	13/20
11	15/20		**33**	16/20
12	13/20		**34**	17/20
13	15/20		**35**	19/20
14	14/20		**36**	13/20
15	13/20		**37**	11/20
16	16/20		**38**	15/20
17	12/20		**39**	14/20
18	14/20		**40**	13/20
19	14/20		**41**	12/20
20	14/20			
21	11/20			
22	13/20			

2.4.4 Results of Synthesis

This section presents a synthesis of the qualitative data results. To conduct the synthesis, the themes of all the included studies were taken from each data extraction form and listed together. Clusters of themes which shared similar features were grouped and labelled with a title that described the overarching meaning of the themes. Five main themes emerged from the mental health population group's experiences of spirituality which were:

Theme 1: Enhancing well-being and recovery

Theme 2: Support for living

Theme 3: Connection with God

Theme 4: Negative aspects of religion

Theme 5: Personal meaning

Theme 1: Enhancing well-being and recovery

Twenty-one out of forty-one studies identified the benefits of spirituality in relation to psychological well-being and recovery. Experiences of spirituality were described as life sustaining which is illustrated in the following extract:

> "I'd be dead… I would be, honestly, because that's what kept, that's what's saved my life…That's it, the bottom line really…I'm, I'm I'm living because of God…That's the most important thing… Regardless of how I experience God… It has been that recognition, ah, that has kept me alive".
> (Wilding, May and Muir-Cochrane 2005: 5)

In relation to protecting life, spirituality was seen as a source of control in the experience of mental illness which is depicted below:

> "…it (spirituality) helps me get the power to control the situation so I don't kill myself. It helps me with the power to change the negative energy into positive energy".
> (Starnino and Canda 2014: 285)

Concerning psychological well-being, the review identified accounts in which spirituality was suggested to sustain mental health which is seen in the following extracts refering to the impact of spirituality on depression:

> "When I think about it (higher power), even just thinking about it, I feel better".
> (Sorajjakool, Aja, Chilson et al 2008: 526)

> "Well, yeah, like I've had my bad times, obviously with bipolar, I've had serious severe depression and a couple of times I've been suicidal. But there's always been a sort of inner voice, a spiritual one, sort of saying, things will get better, this is only temporary, you know".
> (Corry, Tracey and Lewis 2015: 513)

Experiential accounts made reference to spirituality as a source of hope which was key to recovery in order to cope with mental illness. This view was supported by participants who explained:

> "I find that at my lowest points during an illness…I still have that sense that there's some higher power that's going to get me through it and I still bring that a bit into recovery".
> (Green, Gardner and Kippen 2009: 6)

> "I don't worry that my mental illness is a terminal illness. I don't fear it, but I fear becoming hopeless. Having a Christian belief, I understand that my God will help me and save me".
> (Young 2015: 5)

The review found that relief from mental illness was linked to a sense of peace which was facilitated through spirituality. In the following extracts the participants refer to peacefulness and feeling calm which is achieved through their spiritual beliefs.

> "(Spirituality) refers to a sense of peace, stability, and tranquillity…a moment of staying calm".
> (Ho, Chan, Lo et al 2016: 6)

> "It helps. It makes me feel calm, and accept things, not worry so much. Helps me realise I need to let it out, let it go, and things will get better".
> (Keefe, Brownstein-Evans and Polmanteer 2016: 725)

The extracts demonstrate the range of positive impacts of spirituality on mental health which emerged from the findings of twenty-one studies.

Theme 2: Support for living

Within this theme sixteen of the forty-one studies identified experiences of spirituality relating to support with mental illness. Social support from religious groups was experienced which is expressed in the following extracts:

> "It's kind of like we pray, we worship and everything…it's not always spiritual. That's the part where you worship together, but you get involved afterwards…they have donuts or something and that's important. I know quite a few people there and they help me quite a bit…just be my friends".
> (Sullivan 1993: 130)

> "I have been a Catholic all my life and I know for a fact that the Catholic Church has done wonderful things for people, and I am one of them. Whenever I needed help, they were there for me".
> (Russinova and Cash 2007: 276)

The social support helped people to feel less isolated during the experience of mental illness. Specifically, support through prayer facilitated the development of personal relationships which is demonstrated in the following extract:

> "we can move forward together and like when I'm feeling down or unwell she'll pray for me and stuff and …when she's unwell I'll pray for her".
> (Heffernan, Neil, Thomas et al 2016: 350)

In addition, support was experienced in the form of guidelines for life which were provided through religion. Participants recalled the experience of personally identifying with religion and accepting guidance which was directly experienced a source of support:

> "With the depression it helped me even better because the Bible would bring me to certain chapters that would identify with me".
> (Laird, Curtis and Morgan 2016: 7-8)

> "God opened doors for me. Like I had no care, I had no care, I had no job…I was down and out. And I prayed, and I did everything God told me to do. And now I'm back up".
> (Keefe, Brownstein-Evans and Polmanteer 2016: 727)

Guidance from spirituality was also evident in relation to personal meanings and values which influenced how people chose to live their lives.

> "So, I could not live my life today without a spiritual way of being."
> (Corry, Tracey & Lewis 2015: 513)

> "Spirituality is something that moulds your values. Then your values influence the way you behave and conduct yourself".
> (Chan and Ho 2017: 35)

The theme of support emerged in the wish to discuss spiritual needs with mental health nurses which was expressed in the following extract:

> "I want to talk about it…I think it's very important to figure it out. I feel that if I got help from the nurse, then she would understand what I mean with my thoughts and experiences… and then maybe I would get a better understanding of my spiritual life and feel better."
> (Koslander and Arvidsson 2007: 600)

The extract suggests the importance of spirituality to people with mental illness. Overall, the theme of spirituality as a form of support in coping with the experience of mental illness was identified in the review.

Theme 3: Connection with God

Fourteen studies identified the experience of a personal connection with God which enabled people to cope with their mental illness. One participant described how the relationship with God began with the onset of mental illness:

> "I was so ill…I became interested in healing…It's like hanging on to the end of a cliff you've got nothing else…You know the doctors can't

> help you…and ah, you're sort of desperate…and it's when you're at you lowest then…I looked at myself. I was in so much pain. I thought, is this all there is to life?...well if I hadn't got mental I wouldn't have got spiritual…a lot of people do reach some sort of crisis in their life…which makes them search for other things outside of themselves".
> (Wilding, Muir-Cochrane and May 2006: 147)

The connection with God or a higher being was described as one that was close and supportive:

> "spirituality is a…a kind of deeper, more personal thing, uh…personal relationship with a higher being of some sort".
> (Russinova and Cash 2007: 277)

> "Very early on I began to regard this transcendence or this God as my very best friend".
> (Corry, Tracey & Lewis 2015: 510)

Directly speaking to God was found to help some people with the expression of their feelings and consequently enhance their mental health:

> "After I talk to God, I feel very calm, I feel satisfied peaceful in mind, I ventilated and tell God what is going on, I always talk to Him, I always share with God because that makes me happy".
> (Nabil, Saini, Nasrin et al 2016: 105)

> "Spirituality is just an authentic, personal relationship with God, and for me, through Christ. You know, which I can bring all my sorrows, all of my hurts, and there's plenty of grace".
> (Russinova and Cash 2007: 277)

For some participants, the relationship was found to play an important role of companionship which was described as follows:

> "He is there! He is always there. He is my best friend. I can always talk to Him…He always does come. Amidst all this sorrow and pain, He can despite all, still come, with His peace. You can, despite all, feel calmness".
> (Lilja, DeMarinis, Lehti et al 2016: 5)

> "He is always there when one needs him most".
> (Prout, Ottaviano, Taveras 2016: 2147)

The close connection with spiritual and religious beliefs played a role in coping with the symptoms of mental illness which is illustrated in the following extracts:

> "I really feel sad when bad things happen, but I sit, listen to the Qura'an and feel better. My family is the same. Religion helps you adapt, prayer distances Satan from me and the more I pray the more God protects me".
> (Al-Solaim and Loewenthal 2011: 178)

> "I always have audio-hallucination, ie. a boy's voice talking to me. I realise that this voice is in fact an hallucination. When this hallucination comes, I pray to God to help me fight it. Then I feel better after praying and have peace in my heart".
> (Young 2015: 6)

The connection with spirituality and religion helped people to make sense of their experience of mental illness which helped with the process of recovery:

> "I used to pray for the love of God and I didn't pray because someone forced me to do it, I actually loved God that much, I loved the prophet more than myself…you have to do it from the heart…the person who made you on this planet has not made you and left you like this. He still cares for you… I think faith plays a massive part in recovery".
> (Heffernan, Neil, Thomas et al 2016: 339)

The relationship with God provided a feeling of protection in the form of religion which helped in coping with the symptoms of illness.

> "I always have a Bible with me. When I feel I am in danger, I read it and I feel I am protected. It helps me to control my violent actions".
> (Mohr, Brandt, Borras et al 2006: 1954)

According to the views expressed by participants, a close relationship with God was found to be beneficial in coping with mental illness.

Theme 4: Negative aspects of religion

Fourteen studies reported negative experiences of religion which manifested through different aspects one of which was the impact of a negative

relationship with God when facing mental illness. One participant described the experience of feeling abandoned by God when mentally unwell which is illustrated in the following extract:

> "When I am depressed, light is pretty absent, so I can't believe very easily then that light exists. During depression I experience the absence of God, I feel abandoned then, very lonely".
> (Ouwehand, Wong, Boeije et al (2014: 620)

Another study found self-blame resulted from a negative perception of religion and one participant explained:

> "So I felt like there was a vengeful God, that I had done something wrong, that I had sinned in some way".
> (Starnino and Sullivan 2016: 1107)

The theme of religious doubt emerged during the experience of depression as one participant explained:

> "At that moment everything collapsed. Because you build up a picture and you think: this is my path, it is predestined. And then you experience depression and you really start to doubt. My whole spirituality collapsed and after this I did not bother with any of it for a year".
> (Ouewhand, Muthert, Zock et al 2018: 43)

Religious coping through reading the Bible was found to have a negative impact which is described below:

> "I suffer from being so isolated. I was not a believer, but I went to church in order to meet people. But when I read the Bible, it disturbs me. I began to think I have behaved wickedly and then I believe I am the devil".
> (Mohr, Brandt, Borras et al 2006: 1957)

The experience of stigmatisation from religious communities due to mental illness was evident in a study which specifically focussed on the experience of women living within a Jewish Haredi community. One participant described:

> "Like we weren't, weren't seen as human any more".
> (Whiteley, Coyle and Gleeson 2017: 282)

An additional negative aspect was the struggle to maintain religious and spiritual beliefs during the experience of mental illness which was expressed by the following participant:

> "it's through not continuing with your prayers and your rituals that stop you from being religious and sometimes when you leave religion you become unwell…You've said to God I don't want you anymore".
> (Heffernan, Neil, Thomas et al 2016: 349)

In relation to seeking support, spirituality was perceived negatively in terms of difficulties in discussing the topic with mental health professionals. One participant stated:

> "You have to be very cautious about what you say because being not main stream, a little off track, you have to be very careful you're not condemned for what you believe by the professionals".
> (Macmin and Foskett 2004: 27)

The decision to disclose spiritual beliefs was found to have negative consequences:

> "I don't tell people because they don't believe ya, you know. So it's not worth it."
> (Wilding, Muir-Cochrane and May 2006: 148)

The negative experiences of spirituality highlight the complexity of the relationship between spirituality and mental health.

Theme 5: Personal meaning

Eleven out of forty-one studies in this systematic literature review identified the personal concepts of spirituality which are illustrated in the following extracts:

> "It's your journey …through life".
> (Wilding, Muir-Cochrane and May 2006: 147)

Spirituality was experienced as an ongoing personal journey. It also provided personal meaning and purpose in life which is explained as:

> "It's my essence, I think".
> (Corry, Tracey and Lewis 2015: 513)

> "what makes you want to get up in the morning…what your purpose is, what makes you feel good, what makes you want to live – that is spirituality".
> (Russinova and Cash 2007: 278)

> "a personal thing, something you feel inside".
> (Starnino 2016: 299)

The personal significance of spirituality was linked to the ability to cope with mental illness which is evident in the following extracts:

> "It's very strong (spiritual awareness)…I guess I could even say that without that I probably would still be quite unwell.
> (Green, Gardner and Kippen 2009: 5)

> "I'm not a holy Joe. I wouldn't be kneeling praying all day and going to (mass). If I miss mass I don't feel guilty. I believe in all different faiths. I wouldn't be eating up the alter rails. I just believe in talking to the holy spirit like a friend and our lady…All I know is I need it and it's helping me to be able to cope with every day…I know I'm not a holy Joe by any means but I'm just doing what keeps me sane".
> (Carlisle 2015: 123)

The review found that spirituality was described as an individual concept to the participants which was important to defining personal identity, meaning and purpose in life. Overall the themes point towards the significance of spirituality in the lives of people with mental illness.

2.5 Discussion

This section will provide a discussion of the review, beginning with a summary of the key findings and the implications of the findings for practice.

2.5.1 Summary of findings

The review involved a comprehensive search of the literature in order to answer the review question concerning the experience of spirituality and mental health. The search gathered 104 studies and following the selection process, 41 studies were included in the review. The studies included in the review were qualitative with variation in the level of rigour. Five main themes emerged from the experiences of spirituality which were 'Enhancing well-being and recovery', 'Support for living', 'Connection with God', 'Negative aspects of religion' and 'Personal meaning' which were consistent with previous literature.

2.5.2 Limitations

The results of the search process could have been affected by a number of factors which may have led to biased results. Potential bias in the search strategy could have been caused by the fact that the search was limited to English-language articles which perhaps removed findings from significant papers and excluded key cultural factors (CRD 2009: 17, Lockwood, Porritt and Munn et al (2017). Bias could have been introduced unintentionally by the selection of electronic databases which identifies published journal articles and excludes unpublished research, known as publication bias (CRD 2009: 16-17). A manual search for relevant literature was conducted to retrieve studies that

were unavailable from the electronic databases therefore, the search was not limited to the electronic databases which was an attempt to minimise the impact of publication bias. Furthermore, wider searching could have been employed to limit bias. Bettany-Saltikov and McSherry (2016: 178, CRD 2009:18) suggest contacting key experts in the field to identify unpublished research however, the review was limited by time and the resource of one researcher.

2.5.3 Limitations of study selection

Studies were selected for the review firstly by reading the title and abstract of each paper then by reading the full article to identify the studies that met the inclusion criteria. The reasons for excluding papers from the review was if the study was not of a qualitative research design, or the focus was not on the lived experience of spirituality of the specific population group.

A second reviewer is recommended as best practice to ensure that the inclusion criteria has been correctly applied and therefore to increase the reliability of the study selection process (CRD 2009: 24, Pettigrew and Roberts 2006). The Director of Studies for this research performed the role of a second reviewer by screening a sample of 14 papers to clarify the decisions made during the selection process and to minimise subjectivity. This stage of the review could have been enhanced through piloting the study selection forms which is recommended by the CRD (2009: 24), however this approach was not adopted due to a limited time frame.

The various issues of poor methodological quality suggest a negative impact upon the findings of the review. The results section highlights the limitations in relation to the gender and ethnicity of the participants and issues concerning sample size. As a consequence, the conclusions drawn from this review are only as good as the quality of the included studies.

Further limitations of the review may be due to the potential introduction of bias through the process of conducting the review independently. In particular, the stages of reading the studies for the purpose of selection, the assessment of quality and data extraction may have led to subjective findings. In an effort to minimise bias however, the Director of Studies acted as a second reviewer to independently assess a sample of the studies for quality and inclusion in the review which was followed by a discussion of the key quality issues.

2.5.4 Implications of findings for clinical practice and further research

A common feature among many of the studies in this review was the recommendation for clinicians to pay attention to the spiritual needs of service users in order to support recovery and provide holistic care.

Through conducting this review, it has been identified that only 11 studies were conducted in the UK therefore, further research is required to enhance knowledge on the understanding of spirituality from the UK perspective. In addition, the review has identified that only 2 of the 11 UK studies stated the inclusion of people from a BME population, an absence

which suggests that the voices of this group are silent within this field of research which has implications for practice. This is significant given that within the UK, 13% of the population representing 8.1 million people belong to an ethnic minority group according to the 2011 UK Census (Office for National Statistics 2012). Inequalities within UK mental health services are experienced by minority ethnic populations and are well documented in government policy (DH 2003; DH 2005; DH 2010; Grey, Sewell & Shapiro et al 2013: 147). This review highlights that a study is needed that will give voice to the experience of BME individuals with mental illness in the UK. This is what the next study of my PhD aims to do. Understanding this will be significant for broadening clinicians' understanding of spirituality and developing mental health practice for BME communities.

2.6 Conclusion

The objective of this review was to establish what spirituality means to people with mental health problems through searching for papers on the lived experience of spirituality and mental health. This systematic review has identified a range of accounts from adults with mental illness concerning their experience of spirituality. The results of this review suggest that there are five themes which indicate that spirituality plays an important role in sustaining mental health and provides a vital support mechanism for people who are living with mental illness. The experience of spirituality is one which is personal, complex and nuanced however, few papers have directly included the voice of BME participants which indicates the importance of this study. The following

chapter will present the research methodology to explore the meaning of spirituality from the perspective of people living with mental health problems who are from a BME background.

Chapter 3

Methodology

In this chapter I present the research methodology employed to study the topic of spirituality and mental health. The methodology is described by Langdridge (2007: 4; Sullivan, Gibson and Riley 2012: 12) as the underpinning philosophy of the research which considers the assumptions made about knowledge and reality, therefore determining the choice of methods employed. Firstly, in this chapter I provide a description of Interpretative Phenomenological Analysis (IPA) and the reasons for the selection of the approach. Secondly the theoretical underpinnings of IPA are discussed in detail which include the epistemological position, the influence of phenomenology, hermeneutics and idiography. Justification for the choice of IPA as the approach for this research follows alongside the consideration of other research perspectives.

3.1 Interpretative Phenomenological Analysis

This study aimed to uncover the meaning of spirituality from the perspective of people from a BME ethnicity who are struggling with mental illness. Interpretative Phenomenological Analysis (IPA) was selected for this research primarily as it is an approach to qualitative research which is focused upon a detailed exploration of human experience, the meaning of personal lived experience for participants and understanding how people make sense of their

experiences (Finlay 2011: 140; Larkin and Thompson 2012: 101; Shaw 2010: 178; Smith 2004: 40; Smith 2011: 9; Smith and Eatough 2016: 50; Smith, Flowers and Larkin 2012: 1; Smith and Osborn 2015: 25). A central feature of IPA research is to give voice to a phenomenon through the interpretation of experience, the purpose of which is to understand the topic through the lens of the participant's perspective (Shaw 2010: 179; Larkin and Thompson 2012: 101; Langdridge 2007:107; Smith and Eatough 2016: 50; Willig 2013: 87). While the emphasis of IPA is upon the individual's experience, Biggerstaff and Thompson (2008) maintain that the researcher's interpretation of the experience is a key factor in the analysis. In my professional experience as a mental health nurse, I observed that spirituality is often not prioritised for people with mental illness. This study aimed to give voice to individuals with mental health problems which was a significant factor in the selection of IPA.

It is argued that IPA analysis goes beyond description and understanding individual experience. Larkin, Watts and Clifton (2006: 113; Shaw 2010: 178) argue that the goal of IPA is also to examine what personal experience means for a particular person within a specific context of their lives. Rather than accepting the experience at face value, wider factors are acknowledged in the interpretation to establish the meaning of routine experience as it is lived such as social, cultural, historical and political aspects alongside the person's feelings, beliefs and behaviours, a concept referred to as 'lived experience' (Eatough and Smith 2008: 181; Van Manen 2014: 39-42; Willig 2013: 17). The process of interpretation involves stepping outside the descriptive account and

recognising the connection between the person and their world to reveal the complex and individualised layers of meaning. In relation to the research therefore, the focus was to understand 'what does spirituality mean for this particular person from a BME background in this social and cultural context?' which is suited to the IPA approach.

IPA seeks to gain the texture of experience yet acknowledges that direct access to an individual's experience is not possible (Finlay 2011: 140; Willig 2013: 87). Oxley (2016: 55) highlights that within IPA there is the recognition that making sense of the participant's experience is only possible through the participant articulating their account as the researcher cannot directly participate in the experience. Smith (2011: 9-10) therefore suggests that IPA research is concerned with attempting to be as close to the experience as possible. Access to the experience is achieved by firstly the participant expressing their account of making sense of their personal experience and secondly, the researcher attempting to make sense of the participant's personal experience by considering the meaning of the experience, a process of interpretation which is known as a double hermeneutic (Finlay 2011: 141; Gibson and Hugh-Jones 2012: 132; Shaw 2010: 179; Smith 2004: 40; Smith 2011: 10). The analysis is acknowledged as the researcher's interpretation of the individual's experience with the recognition that access to the experience implicates the researcher's personal world and the communication between the researcher and the participant (Brocki and Wearden 2006: 87; Finlay 2011: 140; Willig 2013: 87). This study aimed to seek out the meaning of the human experience of

spirituality and as a consequence of the double hermeneutic approach, the research involved a focused analysis of the participants' accounts of spirituality in order to closely access the experiences.

Criticisms of IPA

The use of IPA has been strongly criticised by Paley (2017: 145-147) as a qualitative research approach which lacks clear criteria of the specific procedures which are employed, resulting in an absence of standardisation, idiosyncracies within research methods and misrepresented data. Paley's criticism of IPA concludes that the findings are the researcher's opinions of experience rather than accurately capturing the meanings of experiences. Smith, Flowers and Larkin (2012) however, have argued that the methodological underpinnings of IPA are firmly evidenced within the increasingly vast number of IPA publications. Alternatively, the flexibility of IPA is suggested to be beneficial in opening up new ways to understand complex experiences. Larkin, Shaw and Flowers (2018) propose that current innovative IPA research using multiple perspectives rather than homogenous samples to explore a shared phenomenon are studies which build upon existing IPA methods to reveal alternative ways of thinking about IPA research design. From my experience as an IPA researcher, IPA is a subjective research approach however, my understanding of standard IPA methods was developed through the IPA training, support from the IPA regional meeting and engagement with the IPA online forum which have enhanced the theoretical underpinnings of this research.

Other critics of IPA consider the limited recognition of the role of language (Willig 2008). In response to this criticism, the interpretation of experience in IPA occurs within the context of exploring narratives for the specific use of language such as laughter, pauses, fluency, metaphors, repetition, the use of pronouns and tone of voice (Finlay 2014: 126; Pietkiewicz and Smith 2012: 367, Smith, Flowers and Larkin 2012: 367). A description of the linguistic analysis used in this research is provided in chapter four.

An additional critique of IPA is the reliance upon the narratives of participants which raises the question whether the participants have the sufficient skills to communicate the details of their experiences and therefore the approach is perhaps best suited to only the most articulate individuals (Willig 2008). Tuffour (2017: 4) argues that the criticism suggests elitism whereby only individuals with specific levels of language ability are interviewed to describe their experiences and therefore recommends that IPA researchers are aware of the criticism to ensure careful attention is paid to the collection of rich data and that steps are taken for sufficient analysis to give voice to the experiences of participants.

A further limitation identified with IPA is that in seeking to understand experience, the approach does not explain the reasons why experiences occur (Willig 2008). Smith, Flowers and Larkin (2012) however, argue that IPA draws upon the idiographic and contextual analysis of the narratives to understand the cultural context of the experiences. A description of this stage of the analysis

which explored the context of the themes in relation to key life events, time and cultural influences is provided in chapter four. In summary, the criticisms of IPA highlight the need for IPA research to clearly demonstrate a thorough interpretation of the data to give voice to the nuanced experiences of the participants.

3.1.1 Epistemological position of IPA

The epistemological basis of the research informs the position of what can be studied and concerns the underlying assumptions about knowledge, together with the approach to reality known as ontology (Sullivan 2010: 17; Sullivan, Gibson and Riley 2012: 12-14). Epistemology refers to how we can know what exists while ontology refers to our assumptions of what exists in the world (Coyle 2016: 11). The study's epistemological position therefore directly informs the methodology and involves clear identification of the research objectives and the possible body of knowledge that can be discovered (Willig 2013: 4). In relation to this research the objectives are concerned with understanding the meaning of spirituality and the study aims to produce knowledge about how participants experience their personal worlds of spirituality when living with a mental illness.

For this research, a critical realist epistemological position has been chosen which Willig (2013: 11-16) suggests is a combination of the realist perspective which seeks to examine the 'reality' of the world and events through the data gathered and the recognition that direct access to that reality is not

possible. Furthermore Coyle (2016: 17; Shaw 2010: 178) suggest that a critical realist position makes the cautious assumption that the experience is real for the participants although care is taken to consider the relationship between the interview content and the actual experience of the person. The reality exists for the participants and is independent of the researcher therefore that reality cannot be known with certainty and is accessed through careful analysis of the participant's subjective experiential account of the events which reveals an insight into the person's thoughts and beliefs about the phenomenon. For the participants in this research, a critical realist perspective assumes that the data provides information about spirituality however, the data is not a direct representation of reality and requires interpretation of personal accounts to identify and access the experience of spirituality.

IPA methodology is underpinned by the assumption that people do not passively perceive reality but instead have the capacity to make sense, or interpret, their personal experiences (Brocki and Wearden 2006: 87; Finlay 2011: 40). Based on this assumption, IPA therefore is committed to reflection on how participants subjectively make sense of personal experience. The epistemology of IPA is interpretative phenomenology which assumes that knowledge about the world is generated by the understanding of experience and how a person relates to their personal world (Larkin and Thompson 2012: 102; Willig 2013: 96). The significance of the person's world is in accordance with that of critical realism which recognises that a person's reality is constructed socially rather than in isolation from social interactions (Sullivan,

Gibson and Riley 2012: 16). Eatough and Smith (2008: 46) suggest that the assumption of the knowledge that can be gained from IPA requires the researcher to identify the person's 'objects of concern' and the 'experiential claims' to understand their account. In addition, IPA assumes that different people can experience the same phenomenon (in this case spirituality) in unique ways because experience is influenced by the thoughts and feelings of the person which leads to a sense of meaning of events (Willig 2013: 96). This research is consequently concerned with a detailed focus on how particular people who are immersed in their particular worlds experience spirituality rather than making generalised claims about the external world.

To examine individual experience IPA methodology is informed by the underpinning theoretical principles of phenomenology, hermeneutics and idiography (Finlay 2011: 140; Oxley 2016: 55; Pietkiewicz and Smith 2012: 362; Smith 2011: 9; Smith and Eatough 2016: 50; Smith, Flowers and Larkin 2012: 4-11; Wagstaff, Jeong, Nolan et al 2014). The following section explores the underlying theory of IPA, beginning with phenomenology.

3.2 Phenomenology

Central to IPA is the philosophical approach of phenomenology which is concerned with the study of human lived experience, focusing upon a detailed examination of the way that phenomena appears to the person (Eatough and Smith 2008: 180; Langdridge 2007: 21; Smith 2011: 9; Smith, Flowers and Larkin 2012: 11; Smith and Osborn 2015: 11; Sullivan, Gibson and Riley 2012:

16). The term ‘phenomenon’ is described by Van Manen (2014: 65) as an experience or an event which is lived through by the individual and appears in the person’s awareness. IPA draws upon phenomenology with the aim of examining everyday experience to make explicit the personal meanings attached to an individual’s experience. In particular, the participant’s perceptions, concerns and engagement with the phenomenon are examined to understand how a person experiences their world (Finlay 2011: 3-16; Langdridge 2007: 107; Larkin, Watts and Clifton 2006: 117; Pietkiewitz and Smith 2012: 362; Shaw 2010: 177; Smith and Eatough 2016: 50; Van Manen 2014: 58-65). Existential issues are the focus of phenomenology to discover the meaning of being human through giving voice to individual experience (Finlay 2011: 3-19; Van Manen 2014: 44). Consequently Langdridge (2007: 17-21) highlights that first-hand accounts of experience are essential which therefore informed the choice of data collection methods to interview the participants. In relation to this research, the intention is to learn about the phenomenon of spirituality from gathering rich descriptions of the different ways in which the experience of spirituality presents itself to individuals.

The significance of the examination of experience to enhance knowledge was argued by the philosopher Edmund Husserl, who is considered to be the founder of phenomenology (Langdridge 2007: 21; Smith and Osborn 2015: 11; Sullivan 2010: 31; Wagstaff Jeong, Nolan et al 2014: 2). Husserl was interested in the world as it presents itself to individuals and advocated phenomenological inquiry should go ‘back to the things themselves’ meaning

that knowledge should be generated directly from the unique features of the phenomenon of interest by setting aside our preconceived ideas about the world (Wertz, Charmaz and McMullen et al 2011: 53; Willig 2013: 83). The concept informed the commitment to exploring subjective experience in the way that it occurs, to discover the richness of how the world is experienced rather than the urge to fit the experience into predetermined categories (Eatough and Smith 2008: 180; Smith, Flowers and Larkin 2012: 1-12). Husserl maintained it was critical to perceive the world as it is through lived experience within particular contexts which was only possible from returning to the things themselves (Langdridge 2007: 12; Willig 2013: 83). This concept highlights IPA's focus on the attention to experience which in this research relates to identifying the unique features of spirituality.

Husserl was specifically interested in the experience of an individual's consciousness. He used the term 'intentionality' to illustrate that consciousness (or awareness) is always in response to an object of attention therefore, experience is always consciousness or perception of (or about) something in the world (Smith, Flowers and Larkin 2012: 13; Wertz, Charmaz and McMullen et al 2011: 52). At the heart of phenomenology is the focus upon the intentional relationship between a person's consciousness and the world, which refers to the different ways in which the world is experienced (Langdridge 2007: 13; Willig 2013: 83). The importance of intentionality is it highlights for the research the significance to focus on the experience of how spirituality appears to the person and the various meaningful ways in which it is experienced.

Husserl's phenomenology required a move away from our taken for granted everyday experience of the world, known as our natural attitude. Husserl defined the everyday life as the 'lifeworld' which provides the context for experience and the focus of phenomenological inquiry (Langdridge 2007: 23; Smith, Flowers and Larkin 2012: 15; Van Manen 2014: 39-43). The term refers to the person's world as it is lived which highlights that it is the experience of everyday life which is at the heart of phenomenology. In order to engage in phenomenology, the challenge was to develop a phenomenological attitude, rather than a natural attitude which was necessary for a detailed focus upon our everyday experience. The concept involved disengagement from our daily activities and a focus upon our taken for granted experience of the world, to return to the things themselves as they appear through lived experience (Smith, Flowers and Larkin 2012: 12-14; Van Manen 2014: 43). Finlay (2011: 23) describes the phenomenological attitude as an open approach to the phenomenon which requires the researcher to be curious and reflective, a demanding process known as dwelling with the phenomenon which informed the analysis of the participant's accounts.

To develop a phenomenological attitude, Husserl suggested bracketing our habitual everyday assumptions (shaped by context, culture and history) in order to focus attention upon how we perceive the everyday world to identify the unique components of the phenomena (Larkin and Thompson 2012: 102; Pietkiewicz and Smith 2012: 362; Smith, Flowers and Larkin 2012: 13-14). Husserl used the term 'epoché' to refer to the concept of bracketing which

involves adopting an approach of doubt concerning the natural attitude, or everyday knowledge of the world (Langdridge 2007: 17). The intention of epoché is to see the experience from a fresh perspective through setting aside biases and pre-understandings to make contact with the experience as it is lived by the person (Finlay 2011: 23; Van Manen 2014: 222-224; Willig 2013: 83). The ability to set aside assumptions about the world enables the researcher to remove the distractions of preconceived ideas to focus upon the 'things appearing' as if viewing it for the first time with a sense of wonder, in order to reveal the key structures of the phenomenon (Langdridge 2007: 21-23; Smith and Osborn 2015: 11; Van Manen 2014: 222-223). In relation to the research, by bracketing my preconceptions about spirituality, the intention was to view the experience of each participant from a fresh perspective through a return to the things themselves, to discover how spirituality appears to the consciousness of each person. My preconceptions are addressed within the section on reflexivity which is discussed in Chapter 4.

Husserl's phenomenological approach employed a series of reductions intended to urge the inquiry to move away from preconceptions in order to be able to closely examine the unique core features of the experience (Larkin and Thompson 2012: 102). Husserl described the process termed 'eidetic reduction' which strived to discover the essence or 'eidos' of subjective experience as it appears to individuals (Larkin and Thompson 2012: 102; Pietkiewicz and Smith 2012: 362; Smith, Flowers and Larkin 2012: 14). Husserl informs the focus of the research to determine 'what is at the heart of the

experience of spirituality?' through the participant's unique perception of the experience. Langdridge (2007: 18) highlights that the key to the phenomenological reduction is the repetition of the process to reveal the different layers of the experience. Husserl provides IPA with the foundation of reflection and a detailed systematic approach to the examination of experience (Wagstaff, Jeong, Nolan et al 2014).

3.3 Hermeneutics

In addition to the underpinning theory of phenomenology, IPA is an interpretative approach and therefore is strongly informed by the theory of interpretation, known as hermeneutics (Eatough and Smith 2008: 180; Smith, Flowers and Larkin 2012: 34). Husserl's phenomenology was developed by Heidegger who's work emphasised that all understanding comes through interpretation which draws on previous knowledge (Langdridge 2007: 24-52; Smith, Flowers and Larkin 2012: 16). The process of interpretative analysis in IPA is informed by Heidegger's concept of 'appearing' which depicts the researcher's approach to facilitate the phenomenon to emerge and then to make sense of the phenomenon during the interpretative analysis (Smith, Flowers and Larkin 2012: 35).

In contrast to Husserl's approach to phenomenology, Heidegger argued that it is not possible to discover a phenomenon's structure by detaching the person from their meaningful world of relationships and activities. Heidegger's interests were in understanding existence and he maintained that people are

immersed in their world therefore existence must recognise the person's personal context of their world and be interpreted (Langdridge 2007: 27-39). The basis of a contextual lens to exploring experience in IPA is influenced by a number of different key figures in philosophy in addition to Heidegger including Merleau-Ponty, Gadamer, Sartre and Schliermacher who developed Husserl's work towards a position of interpretation (Smith, Flowers and Larkin 2012: 21). To enable the exploration of human existence, Heidegger established the concept 'Dasein' to describe the human being as 'being-in-the-world' (Eatough and Smith 2008: 180; Finlay 2011: 49-50; Langdridge 2007: 30 Smith, Flowers and Larkin 2012: 16). The features of Dasein included the subjectivity of humans and the pre-existing social world of relationships, culture, language, objects and activities in which people were thrown into and from which they could not be separated (Larkin and Thompson 2012: 102; Langdridge 2007: 39; Smith, Flowers and Larkin 2012: 17). Finlay (2011: 50; Smith, Flowers and Larkin 2012: 18-21) suggests that immersion in this world shapes our actions, ideas and our ways of being in the world. Heidegger maintained that an individual is a 'person-in-context' and referred to the concept of 'intersubjectivity' to describe the various aspects of engagement with the world and other people (Smith, Flowers and Larkin 2012: 17). These factors in the world place limitations on our existence, yet despite these limitations we are still able to engage with the world and make choices about our existence (Langdridge 2007: 30-39). Hermeneutics therefore provides IPA with the primary focus upon how people make sense of their existence which is in relation to the features of their world (Smith, Flowers and Larkin 2012: 18).

In addition to the context of experience, hermeneutics involves the concept of considering the relationship between the person's body and their world in the interpretation of experience. The work of phenomenologists such as Sartre, Heidegger and Merleau-Ponty referred to the features of existence, or lifeworld, as embodied within culture, language and relationships with others, suggesting that the body is integral to lived experience and our engagement with the world (Finlay 2011: 19-40). Merleau-Ponty argued that our perception of the world is shaped by our embodied existence therefore our bodies are critical to learning about the world and cannot be separated from experience (Finlay 2011: 29; Larkin and Thompson 2012: 102). Smith, Flowers and Larkin (2012: 19) argue that the body is a key feature of experience and must not be overlooked which highlighted therefore, the importance of examining references to the body in the participant's world during the analysis of the experiential accounts of spirituality.

Another key aspect of hermeneutic theory is that of the relationship between time and experience. Heidegger's work argued that being in the world is closely connected with the experience of time as human existence is not static, rather it is constantly progressing with time (Finlay 2011: 50). Langdridge (2007: 30-39) maintains that time is central to our living and the way in which we seek meaning and understanding and therefore shapes our existence. According to Finlay (2011: 52-53) hermeneutics concerns 'horizons of experience' which refers to our process of understanding shaped by temporal horizons of pre-understanding and previous experience. Hermeneutics

consequently provides IPA with the key idea that experience and understanding are temporal therefore interpretation can only occur with prior experience and knowledge.

At the heart of hermeneutics is the focus upon language. The significance of understanding a person's language in IPA research follows from the influence of Heidegger who argued that it was only through the interpretation of language, that existence could be understood. Heidegger described the process of interpreting language, known as the hermeneutic turn, to understand our existence in the world (Finlay 2011: 52). The process of interpretation, known as the hermeneutic circle, is a key concept for IPA which involves developing an understanding of the different forms of relationship between the whole and the individual parts (Smith, Flowers and Larkin 2012: 28). The relationships illustrate the process of interpretation in which to understand a specific part, the whole must be explored, and to understand the whole the parts must be understood which is described in the following table.

Table 3.1 The Hermeneutic Circle (Smith, Flowers and Larkin 2012: 28)

The part	The whole
The single word	The sentence in which the word is embedded
The single extract	The complete text
The particular text	The complete oeuvre
The interview	The research project
The single episode	The complete life

The hermeneutic circle is accessed through each extract and informs the iterative process of interpretation which involves the circular process of the researcher moving back and forth through the data from preconceptions to interpretations to understand the meanings of the parts within the contexts of the whole. (Larkin, Watts and Clifton 2006: 115; Willig 2013: 86). The hermeneutic circle was key to each stage of the systematic data analysis.

For Heidegger, our existence in the world follows the systematic process of meaning making through the hermeneutic circle (Eatough and Smith 2008: 180). Understanding and new knowledge begins with knowledge from previous experience or fore-standing and is deepened through a continuous process of revisiting the initial knowledge and understanding, interpreting the current understandings and moving between the parts and the whole. Smith, Flowers and Larkin (2012: 26-27) suggest hermeneutics offers IPA the idea that the interpretation of experience must recognise the complex connection between the fore-standing and the phenomenon.

For IPA, hermeneutics means a dynamic dual process of interpretation known as a double hermeneutic which is informed by Hiedegger's approach to interpretation (Smith and Osborn 2015: 26-35). In the double hermeneutic process, Smith (2011: 10) states in the first stage of interpretation, the participant is requested to describe and to make sense of their experience, which is their interpretation. In the second stage of the process, the researcher attempts to make sense of the participant's perspective of the experience

(Larkin, Watts and Clifton 2006: 179) which in relation to the research is making sense of the participant's experience of spirituality. Within the double hermeneutic the researcher adopts a dual role, in the sense that the researcher is a person studying people and therefore similar to the participant in sharing the personal qualities of being human but also different to the participant through the role as a researcher employing the systematic interpretative skills to make sense of another person's experience (Smith and Eatough 2016: 51, Smith, Flowers and Larkin 2012: 3). IPA acknowledges that exploring the experience is only possible through the account of the participant and interpretation involves the preconceptions and views of the researcher (Finlay 2011: 140). These issues concerning my personal preconceptions are addressed by reflexivity within Chapter 4.

A final feature of the hermeneutic influence is the balance between two aspects of interpretation. IPA draws on the hermeneutic approach of combining two forms of interpretation, empathic hermeneutics and a critical stance of questioning hermeneutics to interpret and reveal the hidden meanings within personal experience (Ricoeur 1970 cited in Larkin, Watts and Clifton 2006: 115; Smith and Eatough 2016: 51; Smith, Flowers and Larkin 2012: 35; Smith and Osborn 2015: 18-26; Wagstaff, Jeong, Nolan et al 2014: 2). Successful analysis is empathic with the participant's perspective of the experience which provides an insider perspective through a fusion of horizons between the researcher's preconceptions and the text (Smith and Eatough 2016: 51). In contrast, an outsider perspective is obtained through the approach of suspicion

which includes layers of detailed questioning to interrogate the person's account and make sense of the experience allowing for a richer analysis (Finlay 2011: 64; Gibson and Hugh-Jones 2012: 141; Langdridge 2007: 44-53). Gibson and Hugh-Jones (2012: 141) suggest that hermeneutics provides IPA interpretation with the opportunity to balance both the insider and outsider perspectives of the experience. In Chapter 4, I address my experience of this critical role balance.

In summary, hermeneutics offers significant insightful theory for IPA which informs the systematic interpretation of the complex features of experience. Heidegger and other leading figures in philosophy have influenced the interpretative aspects which are central to IPA. The following section explores the impact of idiography upon IPA research.

3.4 Idiography

The final underpinning theory key to IPA is idiography which is a focus upon the particular (Larkin and Thompson 2012: 102; Smith, Flowers and Larkin 2012: 29; Smith and Osborn 2015: 27). Rather than seeking to make generalisable claims concerning populations, the idiographic principle of IPA seeks to firstly identify the particular within each individual case before moving towards general statements which are made with caution (Pietkiewicz and Smith 2012: 363; Smith, Flowers and Larkin 2012: 29; Smith and Osborn 2015: 27). Idiographic research places emphasis upon the attentive analysis of individual cases of experience therefore enabling statements to be made about

specific individuals (Smith and Eatough 2016: 52; Smith and Osborn 2015: 27). Smith, Flowers and Larkin (2012: 29-32) suggest that an in-depth examination of human experience highlights the common human experiences we may share with the individual which initially may seem different, therefore the focus on the particular can highlight significant shared features of generalised experience which allows for consideration of how others might deal with the phenomenon.

IPA's commitment to an idiographic approach is evident firstly in the detail and depth required in the analysis (Finlay 2011: 140; Smith, Flowers and Larkin 2012: 29). Idiography informs the process of IPA analysis which involves a through exploration of each case before moving to the next individual, an approach which enables significant generalised themes to emerge alongside particular claims concerning the specific participants (Pietkiewicz and Smith 2012: 363; Shaw 2010: 177; Smith and Eatough 2016: 52; Smith, Flowers and Larkin 2012: 32). Secondly, the emphasis on idiography is embedded in the endeavour to understand individual perspectives of experience for particular people within particular unique contexts (Pietkiewicz and Smith 2012: 363; Smith and Osborn 2015: 27). Idiography offers IPA research detailed accounts to give voice to the unique meaning of each person's experience and also the similarities and variations of experience across each of the participants (Smith and Eatough 2016: 52). In this study, a key aim was to encourage people with mental health problems to reflect on their unique experience of spirituality in order to consider the personal meaning of spirituality which was enabled through an idiographic approach.

Phenomenology perceives human experience as complex due to factors that experience is unique, subjective, intertwined with the mind, body, world and relationships with others. Consequently, an idiographic focus is required to interpret the subjective characteristics of human life such as emotions, thoughts and chaos in order to understand the phenomenon (Eatough and Smith 2008: 183). Idiography is pursued by the fact that to understand the phenomena each individual is considered within their given context, from their particular perspective (Finlay 2011: 140; Larkin and Thompson 2012: 102). Smith, Flowers and Larkin (2012: 38) suggest that the strength of IPA research is the provision of the deep level of insight into particular human experiences. IPA's commitment to idiographic analysis offers significant contributions to research through making connections between the findings and the wider literature in order to view the current knowledge of the phenomenon from a different perspective. The next section provides a discussion of the reasons for choosing the IPA approach for the research.

3.5 Reasons for Choosing IPA and the Consideration of Other Approaches

The primary focus of the research question to understand personal meaning and the experience of spirituality led to the selection of IPA over other qualitative research methods which followed from the epistemology underpinning the research question. Qualitative research offers a variety of strategies to analyse human experience. Larkin (2015: 249-250) argues that different research approaches highlight different perspectives on the data

through examining the topic in a particular way therefore, consideration was given to other research methods to ensure that IPA was the approach best suited to address the research question. It was recognised that while other phenomenological approaches were suitable such as Descriptive Phenomenology which describes the nature of the experience (Finlay 2011: 94) and Hermeneutic Phenomenology which interprets experience (Langdridge 2007: 122), IPA was selected as the chosen phenomenological method for its focus on the individual and making sense of experience (Finlay 2011: 140). In addition, IPA is recommended by Finlay (2011: 147) for novice researchers due to the structure of the approach and the available guidance, in comparison with the other phenomenological approaches which are less prescriptive. This was my first experience of conducting phenomenological research therefore, IPA was selected as the most suitable method for my level of research experience.

Consideration was given to Grounded theory which is a comparative method that seeks to generate new theories which are developed from the data (Charmaz 2015: 54; Payne 2016: 127). The approach is undertaken to explore social processes at an explanatory level from the perspective of influences and impacts concerning the phenomenon (Eatough and Smith 2008: 43-45; Larkin 2015: 252; Payne 2016: 127; Wertz, Charmaz and McMullen et al 2011: 57). In comparison with grounded theory which involves theory building and the explanation of causes, phenomenological research does not construct theory as the focus is upon a deep examination of human experience, providing possible insights and greater contact with the world (Van Manen 2014: 66; Wertz,

Charmaz and McMullen et al 2011: 280-295). The grounded theory approach would be suited to the research question: What factors influence spirituality? The intent of the research into spirituality was not explanatory therefore grounded theory was not selected for the study.

Discourse analysis was considered as an approach to the research. A variety of discursive research methods are available which are undertaken to explore interaction in relation to a social constructionist approach to knowledge, examining how language is used to construct social realities (Coyle 2016: 165; Eatough and Smith 2008: 44-45; Wertz, Charmaz and McMullen et al 2011: 60,205). The approach would be best suited to research how spirituality is constructed through the social function of language with the question: How do people talk about spirituality? Eatough and Smith (2008: 45; Coyle 2016: 178; Larkin 2015: 252) suggest the primary focus of Foucauldian discourse analysis is upon the operation of power, oppression and social construction through language, with an emphasis towards how things are understood within a particular social context. With this approach, the research topic would therefore be focused upon how spirituality is understood within the social conventions of mental health care which would lead to the research question: How is spirituality constructed in mental health nursing assessments? In comparison with phenomenological research, discourse analysis explores the function of language in relation to how language is used within particular contexts (Wertz, Charmaz and McMullen et al 2011: 283). The epistemological basis of the approach differs with that of IPA (Coyle 2016: 164-165). In IPA, the critical

realist perspective views language as a means of accessing the lived experience whereas the social constructionist approach which underpins discourse analysis examines how people use language to construct their social worlds. Given that the focus of the research question was to understand the lived experience of spirituality rather than its social construction through patterns of language, discourse analysis was not selected for the research.

Framework analysis was explored as a research method which was originally developed for qualitative large-scale policy research and provides a suitable tool for thematic analysis of interview data (Gale, Heath and Cameron et al 2013). The approach is one that is flexible and could have been used to examine the personal experience of spirituality to address a research question such as: What are the experiences of spirituality from the perspectives of BME people with mental illness? Parkinson, Eatough and Holmes et al (2016: 112) highlight that framework analysis was created for qualitative studies with large sample sizes therefore a challenge would be the lack of detailed analysis on lived experience in comparison with the IPA approach. Consequently, framework analysis was not selected for this study.

The exploration of suitable qualitative approaches for this research included the consideration of Thematic analysis. The approach is flexible to apply to most types of qualitative research and focuses on the identification and interpretation of patterns of themes within the data (Clarke and Braun 2016: 84-88). Thematic analysis would be suited to the question: What are the main

themes which can be identified about spirituality in the accounts of BME people with mental illness? Clarke, Braun and Hayfield (2015: 228) specify the key features of thematic analysis which informed the decision not to adopt the approach. Although thematic analysis is used to examine lived experiences, it is not suited to studies with small sample sizes. In addition, the focus on idiography and the detailed exploration of the individual's account is not a feature of this method. A deeper level of analysis was required for this study which led to the rejection of thematic analysis.

The final method considered for the research was that of narrative analysis which describes a number of approaches concerned with the analysis of stories (Smith 2016: 207). The approach centres on the content and structure of people's stories to examine how narrative relates to disclose the meaning of human experience (Eatough and Smith 2008: 43-45; Larkin 2015: 252; Wertz, Charmaz and McMullen et al 2011: 4). The basis for narrative analysis is the concept that stories are the building blocks for meaning and are representative of people's understanding of their lives and experiences. These narratives are placed within the context of other stories in relation to cultural factors and interpretation draws upon a range of theoretical frameworks (Wertz, Charmaz and McMullen et al 2011: 65,224-286). In relation to the research, an appropriate research question would have been 'what story structures do people use to describe spiritual experiences?'. The purpose of the research is to seek access the experience of spirituality through first-person experiential accounts, rather than applying theoretical frameworks to the analysis therefore

IPA was chosen over narrative analysis and other qualitative approaches. Table 3.2 summarises the alternative qualitative approaches considered to explore different aspects of spirituality.

Table 3.2 Consideration of qualitative approaches.

Qualitative Approach	Research Question
Grounded theory	What factors influence spirituality?
Discourse analysis	How do people talk about spirituality?
Foucauldian discourse analysis	How is spirituality constructed in mental health nursing assessments?
Framework analysis	What are the experiences of spirituality from the perspectives of BME people with mental illness?
Thematic analysis	What are the main themes which can be identified about spirituality in the accounts of BME people with mental illness?
Narrative analysis	What story structures do people use to describe spiritual experiences?

Conclusions

In summary this chapter has explored the research methodology and the underpinning theory of IPA. Husserl's work in phenomenology establishes the significance of experience. From hermeneutics, IPA recognises that interpretation of experience is essential, idiography provides IPA with the emphasis on the particular individual. Together these theories shape IPA as an appropriate approach for the interpretation of human experience. IPA addresses the requirement of this research to examine the personal meaning of spiritual experience. What follows in the next chapter is an explanation of the

research methods undertaken in the study which are directly informed by the research methodology.

Chapter 4

Methods

> "*Psychiatry deals in human matters. Should it not then pay attention to the worlds of meaning that its patients inhabit*?'
>
> Diana Rose (2009: 41)

This chapter presents the IPA research design which was underpinned by the IPA methodology to understand human experience. In the first part of this chapter I present the crucial involvement of people who use health care services who contributed to the research design. The ethical considerations are discussed which forms an important part of the research, given the nature of the population group. This is followed by the process of sampling, data collection, reflexivity and data analysis. The chapter concludes with an examination of the quality of the study specifically in relation to the research methods. To begin this chapter, a reminder of the research question and aims is provided below.

4.1 Research Question and Aims

Research question: What does spirituality mean to BME people with mental health problems?

Aims

1. To explore the unique lived experience of spiritual beliefs in relation to BME people living with a mental illness.

2. To examine the role spirituality plays for BME people with mental health problems.
3. To advance scholarship in the area of spirituality and mental health from a UK perspective.

4.2 Service User Involvement

The research design began with the involvement of users of health care services. According to guidelines published by the National Institute for Health Research (NIHR), user involvement in research refers to the contributions of patients and the public in research which would be considered at different levels of involvement such as consultation on aspects of the research (NIHR 2010: 1-2). The study was directed towards understanding the lived experience of people with mental illness therefore the Coventry University Research Support Volunteer Programme (RSVP), a service user research support group, was initially consulted to provide their perspective on the research design and focus. Faulkner (2012: 39) has written extensively to forward understanding of service user/survivor research and highlights that traditionally, service users have held an unequal position in the research process often as the subjects of research with little input into the research design. To address this inequality, the service user group was consulted for critical views on the clarity of the information sheet, the consent form and the interview schedule. Consultation had the advantage of access to immediate service user feedback from people with an understanding of the research process. This was essential at the early stage of

the research design before approaching individuals with mental illness to become involved as participants of the study.

Alternatively, Minogue (2009: 155) writes from the perspective of a regional Mental Health Research and Development Consortium and argues that a possible disadvantage of consultation within research design is that it can be perceived by service users as a tokenistic 'tick box' exercise leaving individuals with little sense of ownership. The feeling of tokenism is reinforced if feedback from the researcher is not provided to those who have been consulted. To minimise possible feelings of tokenism, feedback was therefore provided to the group in relation to their input. It was suggested by the group that the question 'How do you define your spirituality?' was difficult to answer and was similar to the question 'What words would you use to describe your spirituality?' The advice was used to adapt the interview schedule by changing this particular question, which was reported back to the service user group. The discussion and feedback within the consultation was particularly useful in advising on understandable language which informed the interview schedule and as a consequence, may have enhanced the level of participation and a deeper probing of the responses.

4.3 Ethical considerations

Research ethics is concerned with the application of a range of moral principles to provide guidance to research conduct (Thompson and Chambers 2012: 24). Ethical standards in research are influenced by the Declaration of

Helsinki which was produced as a result of the Nuremberg Code at the end of the Second World War (Barrett and Coleman 2005: 555-556). The Code arose in order to prevent human abuse in response to human experimentation by the Nazi regime. Ethical guidelines are underpinned by four key principles; autonomy which refers to the respect for the decision-making capacity of the individual, beneficence which is concerned with balancing benefits against risks, non-maleficence which relates to the avoidance of causing harm and finally, justice which is centred upon fairness (Barrett and Coleman 2005: 565). These ethical principles inform ethical conduct such as the guidance produced by the Royal College of Nursing (RCN). In accordance with these guidelines (RCN 2011), the areas of informed consent, confidentiality, data protection, right to withdraw, potential benefits and potential harms must all be addressed.

Following consultation with the service user group, full ethical approval was obtained on 01/12/2014 from Coventry University Ethics Committee (see page 2). Central to ethical practice is the requirement to continue to review ethical issues throughout the research, following attainment of ethical approval. Smith, Flowers and Larkin (2012: 53; Steffen 2016: 33) identify ethical practice in qualitative research as dynamic and therefore must be considered not only to meet the approval of ethical committees but crucially throughout the process of data collection and analysis such as checking with individuals for continued consent. As part of the approval process, specific issues about risks to participants and informed consent were raised by the ethics committee which

were addressed by the researcher. Consequently, the following ethical issues were considered throughout the research process.

4.3.1 Dual role as nurse researcher

The issue of mental health assessment of the participants was identified by the ethics committee. Feedback suggested more information was required around how the mental capacity of the participants would be assessed and by whom which indicated a lack of clarity around the participants and my role. The ethics committee were therefore informed that the participants were specifically chosen from community mental health voluntary groups rather than health care settings to ensure that they were mentally well. Jack (2008: 58-61) suggests the importance of articulating a clear definition of the researcher's role to participants in order to minimise role conflict. There is the risk that data collection and findings may be influenced when a researcher is identified as a professional nurse. Patients may identify with the more familiar role of 'nurse' and therefore disclose information more freely which leaves participants in vulnerable position (Clancy 2013: 14). As a result of the feedback, the information sheet was amended for greater transparency to clearly state that my role was a researcher, not as a mental health nurse in a clinical position. The consent form included a statement for the individual to indicate that they felt mentally well and were able to participate in the study. The issue of informed consent is discussed in further detail in the next section.

4.3.2 Informed consent

A key aspect of research ethics is the principle of informed consent which is informed by the four key ethical principles. Fully informing participants with clear information about the purpose of the research and the reasons why they have been selected to participate is central to facilitating informed consent (Edwards and Holland 2013: 65-76; Kvale and Brinkmann 2009: 70; Steffen 2016: 37; Thompson and Chambers 2012: 28-29; Wiles 2013: 41-54). Informed consent was addressed prior to the interviews and was revisited at the start of each interview using the participant information sheet and the consent form. The ethics committee highlighted the need for greater clarity in the information sheet regarding which particular black and minority ethnic group were required for the sample. Further information was recommended on whether religion was a requirement for inclusion in the sample to provide transparency of the research design to prospective participants. In response to the advice, the information sheet was amended to explain that religion was not the focus of the study therefore the sample group included people from a range of cultural backgrounds who may be religious or non-religious. Participants were informed that they could self-select if they were from an ethnic minority group.

In relation to the ethical principle of non-maleficence, informed consent entails the avoidance of harm by making explicit any potential risks for the participants (Kvale and Brinkmann 2009: 70; Mann 2016: 76). The ethics committee raised issues around the possibility of participants becoming distressed by the discussion of sensitive issues during the face-to face

interviews. When addressing this principle in qualitative research, Smith, Flowers and Larkin (2012: 53; Wiles 2013: 55-68) identify the importance of considering the level of psychological harm which may be caused by reflecting upon sensitive topics. Finlay (2011: 190) suggests that phenomenological research often touches on difficult personal experiences therefore the need for a careful and sensitive approach with participants is essential. In mental health qualitative research in particular, Thompson and Chambers (2012: 30) similarly argue that there is the potential for harm to emotional wellbeing whilst individuals recall difficult experiences. The need for greater clarity in the information sheet and consent form was specified by the ethics committee outlining the process to be followed if the participants became distressed. Participants were recruited from community mental health voluntary groups therefore to minimise the risk of harm, the recommendation was that support was to be offered from a range of sources particularly if the participant did not wish to discuss the issues with the voluntary organisation to which they were linked. The recommendation is echoed by Smith Flowers and Larkin (2012: 54; Thompson and Chambers 2012: 30) who suggest that it is good practice to inform the participants of how to access additional support if required. The information sheet and consent form were amended accordingly to state that support would be provided to contact a health care professional if required (see appendix 6). At the start of each interview the participants were reminded of their right to withdraw or to stop the interview if they felt distressed.

The process of obtaining fully informed consent however was complex as the participants had agreed to be interviewed yet there was no way of knowing in advance the topics that would arise during each interview, which was particularly evident during the second pilot interview. Finlay (2011: 189; Wiles 2013: 55-68) point to the challenges of predicting in advance the course and the outcome of the interview in which neither the researcher nor the participant can foresee what topics particular people may find upsetting, or how the experience of participation will feel for the individual. To minimise possible harm, the risks needed to be anticipated and communicated to the participants through the process of checking ongoing consent. In particular, individuals needed to know the likelihood of the interview to include sensitive topics and the impact of discussing personal experience. The importance of supervision to prepare for potential risk issues is highlighted by Smith, Flowers and Larkin (2012: 54). Discussions therefore were held during supervision with the Director of Studies and IPA peer groups to anticipate possible risks for participants. The participants were advised of possible risks through the explanation that spirituality is an individual concept therefore it was likely that different people would discuss different experiences. To facilitate informed consent the research was presented to the voluntary groups during the recruitment phase to offer opportunities for participants to ask face to face questions for further information about the study and to clarify their assumptions.

Alternatively, it can be argued that the experience of distress may not always result in harm for participants. Thompson and Chambers (2012: 30)

suggest that the opportunity for emotional reflection can potentially be beneficial for individuals in which a space is created to focus on thoughts and feelings. Consequently, what is essential is that the researcher must be prepared for the possibility of distress and equipped with the skills to manage distress through enabling the participant to decide whether to continue or withdraw from the interview in order to minimise harm. Care was taken by the researcher to manage the interviews with sensitivity and the participants did not display visible signs of distress when discussing aspects of their experience despite describing difficult experiences of mental illness. Body language was monitored for potential signs of emotional harm (Wiles 2013: 55-68) and individuals were asked if they felt comfortable to proceed with the interview when difficult topics had been recalled which was part of the need to clarify ongoing consent. Drawing upon my skills as a mental health nurse, each participant was debriefed at the end of the interview to assess the extent of possible harm caused by the interaction. Sufficient time was allocated to ask participants if they felt distressed and if access to further support was required.

4.3.3 Confidentiality

The issue of confidentiality, which is underpinned by the ethical principles described above, refers to maintaining the privacy of identifiable information of participants and involves informing participants of the situations where confidentiality may be breached (Wiles 2013: 41-54). As a mental health nurse, there are requirements under the professional registration code of the Nursing and Midwifery Council (NMC 2015) to report concerns about individuals in

which there is a risk to patient safety or public protection. The ethics committee recommended more clarity for participants in the information sheet and consent form concerning the circumstances in which confidentiality may be breached. This issue was addressed by making amendments to the information sheet and consent form according to the advice. An example was added to illustrate the circumstances in which confidentiality would be breached and each participant was informed verbally before the interview.

To maintain confidentiality, information was stored in a locked cabinet and electronic data was stored anonymously on a password protected computer. The participants were informed of who would have access to the data. Each interview was allocated a unique number and the transcripts were anonymised in order to share information with the Director of Studies.

4.3.4 Pilot interviews

On completion of the ethical approval process, two pilot interviews were conducted in preparation for data collection specifically for the benefits of developing interview skills and the opportunity to practice the interview schedule (Mann 2016: 118-119). Two service users volunteered to be interviewed which helped to refine the interview questions and to understand the potential risks of harm during data collection. The experience of the first pilot interview highlighted the necessity to have an initial meeting with the participant to determine that the individual was mentally well and had a full understanding of the research. This aspect emerged from the fact that the first

participant was unable to maintain focus on the interview questions. The responses continuously drifted away from the topic and were not linked to personal experiences of spirituality which made the content difficult to follow. From this interview it was difficult to determine the clarity of the interview schedule. It was apparent that despite the fact that staff from the voluntary organisation knew the person and had recommended them to be suitable for interview, it was imperative as a researcher to establish if participation would be appropriate prior to the interview to minimise potential risks of harm to the individual.

The concept of vulnerability in research was examined in an analysis of 11 national and international policies and guidelines (Bracken-Roche, Bell and Macdonald et al 2017). In all the policies, it was found that the practical implications of vulnerability pointed towards careful inclusion throughout the research process. Within the analysis, specific guidance in relation to research design and the process of informed consent highlighted the importance to re-confirm consent using an appropriate format which is tailored to the individual's needs. As a result of the first pilot interview, this approach was adopted throughout the process of data collection.

The second pilot interview demonstrated that the interview questions were appropriate to exploring the meaning of spirituality to people with mental health problems. The data collected was rich and provided information which was relevant to the research question. The feedback from the participant

suggested that specific questions needed to be asked in a way which prepared the person for discussing a difficult experience. Individuals were also to be informed of the importance of taking time to consider their response. The question 'Can you tell me about a recent time when you had a spiritual experience?' led the participant to sharing the experience of a recent bereavement. After the interview, the individual stated that although she was not harmed by the question, she had not expected to talk about such a difficult experience prior to the interview, given the topic of the research, which is in line with the challenges concerning informed consent. The participant suggested that people may agree to be interviewed but not have a full understanding of the topics the discussion of spirituality may involve. The individual did not regret disclosing the information but identified the possible risks in relation to informed consent for future participants. The experience from the pilot interview was used to inform each interviewee of the potential for discussing difficult topics before asking the question about a recent spiritual experience. Following completion of the pilot interviews, the sample was recruited for data collection.

4.4 Sampling

4.4.1 Sample selection

The purpose of recruitment was to select participants who were most likely to provide information relevant to understanding the meaning of spirituality to BME people with mental health problems. The rationale was that much of the literature focused on the clinicians' view of spirituality with little emphasis on the voice of service users, in particular those from a BME background which

was discussed in chapter 2. The sampling strategy remained consistent with IPA theory therefore due to the small sample size, purposive sampling was employed rather than random or representative sampling strategies to enable the recruitment of a particular group for whom the research question would be meaningful (Larkin and Thompson 2012: 103; Smith and Eatough 2016: 55; Smith, Flowers and Larkin 2012: 48; Smith and Osborn 2015: 28). The sample was homogenous in order to provide insight into a specific experience and enable the analysis of similarities and differences across the experiences (Smith and Eatough 2016: 55; Smith, Flowers and Larkin 2012: 49-50; Smith and Osborn 2015: 28). The inclusion criteria for the homogenous sample was BME adults who were living with a mental health problem which was guided by the aims of the study. The sample was influenced by selection factors in that the participants were a hard to reach group and consequently a period of six months was taken to recruit individuals. Participants in the study were selected through approaching relevant groups offering support for people with mental health problems. Voluntary community mental health organisations were contacted rather than hospital services to ensure that potential participants were mentally well enough to participate. A total of nineteen mental health support groups were contacted, two of which had potential participants who fitted the criteria. The groups acted as gatekeepers who approved permission to access the potential participants which helped to further minimise the risks towards a potentially vulnerable group of people. The participants were invited to be involved in the research and consent was voluntary.

4.4.2 Sample size

As a result of the recruitment a total of eight people initially agreed to take part in the research, however three people were not interviewed as they chose to withdraw from the study. Consequently, a sample size of five people was used which met the recommendations for IPA research. A small and purposively selected sample is essential for IPA studies for a number of reasons, one being due to the nature of the idiographic approach (Eatough and Smith: 2008: 187; Langdridge 2007: 109). According to Smith, Flowers and Larkin (2012: 3) the idiographic commitment of IPA means the primary focus is upon gaining a detailed understanding of a particular person's experience, what the experience is like for them and how they make sense of it. A small sample is therefore necessary in IPA to allow the voice of the individual to be heard and for the researcher to understand in depth how a specific phenomenon is experienced and understood by a particular group of people in a specific context (Reid, Flowers and Larkin 2005: 25; Smith, Flowers and Larkin 2012: 29). The emphasis is to learn about the life world of each individual and given that most human experience is complex in nature, IPA research therefore benefits from a detailed focus on a small number of individuals (Smith 2004: 42). In relation to the research the sample size was in keeping with the IPA approach which benefitted from an in depth understanding of the complex experience of spirituality of five individuals.

There is no rule to specify how many people should be included in an IPA sample and there is flexibility in the recommendations for the specific

sample size which influenced the research (Smith 2004; Reid, Flowers and Larkin 2005). Smith, Flowers and Larkin (2012: 51) suggest a sample size of between three and six participants for an IPA study however the sample is considered on a study-by-study basis. Langdridge (2007: 68) states the number of participants should be small and usually between five and six people. Similarly, Smith (2004: 42) states that many studies include samples of between five and ten participants. According to Finlay (2011: 141) three to six participants is a sufficient quantity for comparisons to be made in the data without leading to an overwhelming volume of data. Pietkiewicz & Smith (2012: 364) recommend a sample of this size to allow the researcher to examine similarities and differences within the data. In addition, an IPA study can be conducted with one participant or a larger number of people (Finlay 2011: 141). It is argued that the sample size for a PhD is not necessarily an increase in numbers due to the idiographic commitment of IPA, rather the size is determined by the quality of the data and the research question (Hefferon & Gil-Rodriguez 2011: 756). A sample size of five participants therefore fell within the recommendations for IPA research.

Despite the variation in recommendations, Finlay (2011: 141) highlights that deciding upon the sample size for an IPA study is not a prescriptive process because it is determined by a number of factors. The size is driven by a combination of the richness of the data and practical constraints such as access to the individuals who are prepared to participate in the study (Langdridge 2007: 51; Pietkiewicz & Smith 2012: 364). In relation to the access

and recruitment of the sample, the BME mental health service users were a hard to reach group which was a determining factor in the sample size. The sampling strategy was focused on the quality of the data rather than numbers of participants which lies within the underpinning phenomenological methodology. Van Manen (2014: 352-353) argues that phenomenological research aims at discovering unique lived experience of individuals therefore the findings cannot be generalised from a sample to a wider population. Consequently, the question of how many people should be interviewed becomes irrelevant. The sample is best considered as 'examples' of rich descriptions of experience. The answer of how many examples of experience are appropriate for a study to understand a phenomenon is not dependent upon a specific formula. Phenomenologists search for elements within a lived experience which are totally unique rather than patterns and similarities within data. Studies will either benefit from a few or a large number of interviews, depending on the nature of the research. The expected duration of each interview was one hour with an intended sample size of eight participants. Despite the outcome of five participants, the depth of the data was maintained through my ability to draw upon my skills as a mental health nurse to facilitate each individual to get to the core issues. What is significant is that enough rich accounts of experience have been gathered to provide powerful insights which illuminate life as it is lived by the person. Similarly, the concept of 'information power' is suggested by Malterud, Siersma and Guassora (2016: 1753) to guide the sample size for qualitative research. It is argued that information power concerns the more information the sample provides that is relevant to the research question, the

smaller the number of participants is required. A sample which is specific to the focus of the study, the quality of the interview data and the process of analysis are factors which determine sufficient information power. Each transcript was read by the Director of Studies to monitor the richness of the data which given the difficulties in accessing the participants, informed the decision that a sample size of five individuals was in keeping with the principles of IPA research.

An additional requirement for a small number of cases is the fact that larger sample sizes lead to limitations in data analysis. The required depth of interpretation associated with IPA to fully understand each transcript on a case by case basis takes a considerable length of time and therefore can only be achieved using a small number of participants (Langdridge 2007: 109; Pietkiewicz & Smith 2012: 364; Larkin, Watts and Clifton 2006: 103; Smith 2004: 42; Smith and Eatough 2016: 54; Smith and Osborn 2013: 56-57). The outcome of using too many participants may lead to large volumes of data which would be overwhelming and therefore problematic to retain the subtle meaning within the transcripts and the idiographic focus of IPA (Hefferon & Gil-Rodriguez 2011: 756; Van Manen 2014: 353). It is argued that the most important issue is the quality and depth of the data, not the quantity (Smith, Flowers and Larkin 2012: 51; Langdridge 2007: 58). Wagstaff et al (2014: 4) recognise the value of small samples in IPA whereby the data that emerges from a smaller sample is beneficial as it is rich and of a manageable quantity. Researchers are advised to consider ‘less is more’ by concentrating on the use of smaller numbers of participants to achieve greater depth rather than breadth

in IPA (Hefferon & Gil-Rodriguez 2011: 758; Pietkiewicz & Smith 2012: 364; Reid, Flowers and Larkin 2005: 22). The small sample size of five participants allowed for each transcript to be analysed in great depth which is essential for good quality IPA research. It can be argued that a larger sample may have led to a shallow and descriptive account resulting in a poor IPA approach.

4.5 Data Collection

4.5.1 Justification of semi-structured interviews

Individual face-to-face interviews was chosen as the method for data collection. IPA data can also be collected through other methods which include focus groups and diaries (Smith, Flowers and Larkin 2012: 56-57). Spirituality is a personal subject and the participants may have felt uncomfortable talking about personal issues within a group environment (Steffen 2016: 39). The focus of the research was upon the individual experience of spirituality rather than a group perspective therefore focus groups were not used for data collection. Diaries were not used with the participants as a possible difficulty could have been the level of engagement. The participants were living with mental health problems and may have been unable to commit to participation through maintaining a diary. According to Smith, Flowers and Larkin (2012: 56; Larkin and Thompson 2012: 104; Shinebourne 2011: 50-54) data collection in IPA requires a method which facilitates the participants to provide detailed verbal accounts of their own stories which elicits their thoughts and feelings about their experience. Semi-structured one-to-one interviewing was therefore selected as a suitable method of data collection which is typical within IPA

research to invite participants to explore their lived experience of a phenomenon (Eatough and Smith 2008: 187; Finlay 2011: 141; Larkin and Thompson 2012: 103; Shinebourne 2011: 50; Smith and Eatough 2016: 55; Smith, Flowers and Larkin 2012: 56; Smith and Osborn 2015: 29).

In addition, semi-structured interviews were chosen for the benefits of meeting the idiographic requirement of IPA research (Shinebourne 2011: 50; Smith, Flowers and Larkin 2012: 56). Interviews provide access to first-person accounts in order to focus upon how individuals make sense of their experiences. IPA research requires a flexible data collection method to access such detailed accounts of personal experience (Smith and Osborn 2015: 29). Brinkmann (2013: 49-53; Finlay 2011: 141; Shinebourne 2011: 50) suggest that the strength of face-to-face interviewing lies within its flexibility, with the opportunity for the participant to provide a full account whilst the interpersonal dialogue enables the interviewer to question specific areas as the interview unfolds. Eatough and Smith (2008: 187-188; Smith and Eatough 2016: 55) highlight the benefits of the real-time contact between the interviewer and the participant which enhances the flexibility of the interview to explore the experience and pursue interesting issues as they emerge. Questions were adapted to meet the responses of the participants which allowed the interview to follow a flexible course and enabled the production of richer data (Smith and Osborne 2015: 29-31). Smith, Flowers and Larkin (2012: 56-57) argue that semi-structured interviews allow for the development of a rapport which invites the participants to engage in a reflective dialogue in which they can speak

openly about their thoughts and feelings. Alternatively, an interview which is highly structured would limit the opportunity to gather rich data which is a critical requirement for high quality IPA research. For these reasons, semi-structured interviewing was justified as the optimal method for IPA research.

4.5.2 Research setting

Practical issues were taken into consideration when planning the interview locations. Mann (2016: 62) suggests that each step that is taken to prepare for the interview is influential to how the participants feel about the interview and consequently how the events unfold. The interviews were held at the voluntary organisations to which the participants belonged, for reasons of accessibility for the individuals and familiarity to help them to feel at ease. A quiet room was booked to minimise interruptions in order to enhance privacy and to enable an audio recording of the interview. Edwards and Holland (2013: 43-52; Mann 2016: 60-61) discuss the significance of the interview context as an insight into the participant's lived world by highlighting the relationship of the participant with the site. Visiting the participants at their voluntary group and observing how they interacted with others in that location provided information about the meaning of the place. Within the setting, the participants appeared relaxed and comfortable to talk about their experiences which provided information beyond the dialogue in the interview about the context of their experiences.

4.5.3 Interview schedule

A semi-structured interview schedule was developed and used during the interviews which is recommended within IPA research (Finlay 2011: 142; Smith, Flowers and Larkin 2012: 58). The purpose is to encourage the discussion of relevant topics in order to develop a good interview which is essential to IPA analysis and to answering the research question. The schedule was developed to facilitate a dialogue with the participants in which they felt at ease to offer a rich account of their experiences (Smith, Flowers and Larkin 2012: 59). The questions were linked to the research question and were designed to encourage dialogue about the participants' spiritual beliefs, their experience of spirituality and the role of spirituality within their lives (see appendix 7).

The development of the interview schedule had the advantage of enabling reflection upon the specific questions that were going to be asked, preparation for handling possible challenges and addressing potential sensitive topics (Finlay 2011: 142; Shinebourne 2011: 54-55; Smith and Eatough 2016: 56; Smith and Osborn 2015: 31-32). Smith, Flowers and Larkin (2012: 61) recommend reviewing the interview questions with others to ensure the focus is upon open questions which invite the participant to talk about their personal experience. The schedule was refined following a combination of feedback from the service user group, the pilot interviews and the Director of Studies concerning the level of difficulty of the questions. The schedule was developed to plan an agenda for the order and content of the discussion, and to prepare questions to appropriately address sensitive topics by fore-warning the

participant (Smith and Osborn 2015: 33). A flexible approach was applied to the interview schedule to allow for the emergence of unexpected topics which may have held great significance for the participant and be of relevance to answering the research question (Smith, Flowers and Larkin 2012: 28).

A benefit of the interview schedule was the increase in my confidence as an interviewer as a result of the preparation which helped to minimise my anxiety during the interviews. Smith, Flowers and Larkin (2012: 59) argue that constructing an interview schedule promotes the use of positive interpersonal strategies which increases the effectiveness of the interview by reducing the anxiety of the interviewer which in turn, leads to the participant feeling more comfortable to talk about personal experiences. In addition, Smith and Eatough (2016: 56-58) suggest that learning the interview schedule enables greater concentration during the interview upon the participants' responses. The schedule was practiced and learned prior to the interviews to improve the flow of the dialogue and as a consequence, I was able to focus thoroughly on the participants responses and listen attentively to their accounts.

The interview schedule was constructed with open questions to ensure the interview was led by the participants' concerns and to encourage a detailed response (Finlay 2011: 142; Shinebourne 2011: 55; Smith, Flowers and Larkin 2012: 59). Kvale and Brinkmann (2009: 134) highlight that introductory open questions such as 'Can you tell me about…?' may lead to rich accounts in which the main features of the experience are expressed. The interviews

therefore began with a ‘grand tour’ open question such as ‘Can you tell me what spirituality means to you?’ to encourage general talk about spirituality. Spradley (1979:50) suggests that grand tour questions make sense to participants and invites the person to describe important features about the area of interest. Questions were phrased to be non-leading and non-judgemental for example, ‘Can you tell me what place spirituality has in your life at the moment?’ Shinebourne (2011: 55-56; Smith and Eatough 2016: 57; Smith and Osborn 2015: 34) suggest the use of prompts to probe deeper into areas of interest and to encourage more dialogue where difficulty is anticipated to respond to complex questions. Prompts such as ‘Can you tell me more about that?’ were constructed to encourage more detailed experiential accounts. Kvale and Brinkmann (2009: 134) highlight the use of prompts such as nods and ‘mm’ which were also used to encourage the participant to speak at greater length. While the interviewee was talking, notes were made of key words and phrases as a reminder of topics to return to for questioning in more detail. Smith, Flowers and Larkin (2012: 64) suggests that this method signals the level of detail required and may encourage the participant to continue to talk in depth. The following table provides examples of the interview questions which were linked to the aims of the research.

Table 4.1 Rationale for the interview questions

Rationale linked to the research question	Example from the interview schedule
To discover the role spirituality plays for BME people with mental health problems.	Can you tell me what place spirituality has in your life at the moment?
To discover the role spirituality plays for BME people with mental health problems.	Can you tell me what spirituality means to you?
To discover the role spirituality plays for BME people with mental health problems.	What does practising your faith mean to you?
To discover the role spirituality plays for BME people with mental health problems.	What do you think your family/friends//other people close to you think about your spirituality?
To understand the unique lived experience of spiritual beliefs in relation to BME people living with a mental illness.	How would you describe yourself as a person?
To understand the unique lived experience of spiritual beliefs in relation to BME people living with a mental illness.	Can you tell me about a recent time when you had a spiritual experience?
To understand the unique lived experience of spiritual beliefs in relation to BME people living with a mental illness.	Have you changed the ways you think about spirituality over time?

Each interview began with a review of the participant information sheet and the consent form to revisit and check ongoing informed consent. Information was provided about the study context and the reason for the interview. Demographic information was sought before asking the questions from the schedule. Although the interview schedule was developed to provide a structure to the questions, it was important to recognise that the dialogue could not be predicted in advance. Smith, Flowers and Larkin (2012: 64-65) argue the importance of accepting that the interview style is essential to discovering the individual's lifeworld which involves a balance between adhering to the prepared list of questions and at times abandoning the rigid structure of the interview schedule to follow topics of interest. Eatough and Smith (2008: 188-189; Smith and Eatough 2016: 56; Smith and Osborn 2015:30) suggest that facilitating the participant to provide their personal stories in their own words is essential to IPA research. The participants were perceived as the experts of

their experiences therefore, it was important for their experiential accounts to guide the direction of the interview to meet the phenomenological commitment. The real-time interaction of the interview was unpredictable and as a result, the schedule was used as a flexible tool rather than to dictate the interaction which therefore enables the interviewer to probe interesting issues that emerge and to follow the participants' interests (Smith and Eatough 2016: 56-58). Smith and Osborn (2015: 36) highlight that unprompted responses which are unexpected are often the most valuable insights into personal experience because they are significant to the person therefore allowance should be made to move away from the schedule. Adopting this approach enabled the sequence of the questions to be adapted to the interview and additional questions to be asked to pursue the specific concerns of the participants.

Attention was paid to the complexity of power dynamics within the interviews. The power asymmetry that exists between the researcher and the interviewee is highlighted by Kvale and Brinkmann (2009: 33-34) who recommend that researchers reflect upon the responsible handling of power to address ethical issues. The research interview is a specific data collection tool in which the topic and questions are determined by the interviewer therefore it is not an open conversation between people of equal status. To address the power asymmetry the participants were thanked for their time and were given the opportunity to ask questions at the end of the interview. Vahasantanan and Saarinen (2012:507) argue that power manifests in various forms and shifts between the interviewer and the participant throughout the interview. Power

appears in the interview skills and techniques used by the interviewer and also arises in the choice of interview setting. The participant holds power when responding to the interview questions which is characterised by what they choose to say in relation to their knowledge of the topic (Brinkmann and Kvale 2005: 4). In relation to the fourth interview, the participant exercised her power to have her friend present for support during the interview which was facilitated. I recognised that I was dependent upon her feeling comfortable to talk about her experiences and therefore the friend attended the entire interview to address the power dynamics.

4.5.4 Recording the interviews

The interviews were audio-recorded using a digital recorder primarily because audio-recording is essential for IPA interviews to capture the detail and nuances of everything that the participant has said (Finlay 2011: 141; Smith and Eatough 2016: 58; Smith, Flowers and Larkin 2012: 54 Smith and Osborn 2015: 37). In addition to recalling the interview content, Mann (2016: 115) highlights that a benefit of recording the interview is that transparency is demonstrated in that the findings can be located within the context of the specific interviews, which therefore enhances the quality of the data analysis. Alternatively, Edwards and Holland (2013: 65-76) suggest that a limitation of audio recording could be that participants feel uncomfortable about speaking whilst being recorded. Consent was sought from the participants to make the audio recording and although it was not apparent from my observations of behaviour

during the interviews, they may still have felt self-conscious about the recordings.

A further limitation of audio-recording is that non-verbal communication is not recorded therefore the data collected is not complete (Smith and Osborn 2015: 37). The recording however allows the interviewer to focus attention entirely upon the participant rather than managing the distraction of making written notes to document the interview which would affect the smooth running of the dialogue (Smith and Osborn 2015: 37). During the interviews, the digital recorder provided the opportunity to focus my attention upon developing a rapport with each participant. The recording enabled me to concentrate during each interview upon listening intently to the participants' dialogue, using prompts and follow up questions where required which led to gathering rich experiential accounts. Brief notes were taken while the participants were speaking which allowed me to return to salient topics for further detail.

4.5.5 Transcription

The recorded interviews were transcribed which is a necessary requirement for IPA research to enable interpretation of the person's account (Smith and Eatough 2016: 58; Smith, Flowers and Larkin 2012: 74). In order to produce the detailed transcriptions required for the data analysis, each interview was transcribed verbatim which included the interview questions, non-verbal behaviour such as laughter, 'mm' and pauses in dialogue (Brinkmann 2013: 51; Finlay 2011: 141; Smith, Flowers and Larkin 2012: 73-74; Smith and

Osborn 2015: 37). Wide margins were left on each side to allow space for the analytic comments which is suggested by Smith and Eatough (2016: 58; Smith, Flowers and Larkin 2012: 74; Smith and Osborn 2015: 37).

Although transcription of each interview was a time-consuming process, transcription provided the opportunity to reflect upon aspects of the data which prompted the preliminary data analysis. Mann (2016: 200-205) suggests that the detailed listening that is required to produce the transcription enables the researcher to slow down and begin to immerse in the content of the data. Indicators of hesitancy in speech and what was said and not said in the accounts were considered at this stage. The close proximity to the data that was required to listen to the recorded interviews led to insights into the accounts which may have been excluded if someone else had transcribed the recordings and was therefore the primary reason for producing the transcripts.

4.5.6 Reflexivity

Reflexivity refers to the ongoing process of the researcher building an explicit self-awareness, the importance of which is to recognise their influence upon the development of the knowledge produced to maintain the quality of the analysis and increase the transparency of the study (Coyle 2016: 20; Langdridge 2007; 58-59; Shaw 2010: 234; Storey 2016: 71). Shaw (2010: 233-240) argues that qualitative research involves a relationship which is constructed by the researcher and the participant who share the fact that they are both people with human experiences. The implications which emerge from

people studying human experience must therefore be acknowledged and managed which demands embedding a reflexive approach to the research. Whilst essential in qualitative research, reflexivity must be used with caution. Finlay (2011: 79) highlights the importance of balancing reflexivity against too much self-reflection which risks moving the research focus away from the participants and the phenomenon in the direction of the researcher. Reflexivity should not be the purpose of the research but a mechanism for successful exploration of human experience (Shaw 2010: 241).

Reflexivity was used as a mechanism to examine myself as a researcher and to consider my position in relation to the research. Positionality enables the researcher to develop an awareness of motivations and thoughts about the research to consider how these salient factors may influence the findings (Clancy 2013: 13-15). This is an iterative process that goes beyond self-reflection to bracket beliefs, positioning, understandings and expectations at the start of the research (Finlay 2011: 79-80; Langdridge 2007: 59). Significant factors that I critically examined were my gender, age, ethnicity, religion, my personal experiences, my professional roles and my motivation for conducting the research. My understanding of my identity and my spirituality were important to acknowledge in order to critically examine the impact upon my interpretation of the accounts. Shaw (2010: 234-238) highlights the importance of identifying pre-existing knowledge or fore-standings and their origins to make sense of the participants' experiences and warns against unexpected triggers

which may reveal our preconceptions. I reflected upon my identity beginning with my childhood experiences.

I was born and raised in the town of Macclesfield, Cheshire where I lived with my parents who had migrated to the UK from Mauritius. Religion played a significant role in my upbringing as I grew up in a Muslim family. Few BME families lived in Macclesfield which was a predominantly white, affluent area and I was the only coloured child in my primary school. My peer group therefore consisted of all white children so as a consequence my identity was British, yet I was always conscious of being of a different ethnicity. My parents socialised with friends from a range of ethnic backgrounds so I grew up feeling socially included. My self-development broadened through the experience of leaving home to attend university, progression through my career, my marriage and motherhood. Marriage and parenthood have had a profound impact on my perspective on life and my understanding of others. My faith is important to me alongside my relationship with my husband and my two children, all of which are significant features of my spirituality. All of these factors may have shaped how I was perceived by the participants, my perception of the participants which in turn may have influenced the interview dynamics and the interpretations made.

Through reflexivity, influence is brought to the forefront so that it can be addressed to enhance the quality of the interpretations made. The purpose is to minimise bias through recognition of the subjective factors which may impact

the research enabling the issues to be tackled as they arise, a method known as bracketing (Darawsheh 2014: 561). By making self-awareness explicit through engaging with reflexivity, it is suggested that it is possible to manage fore-standings and to deal with emotional responses which may be triggered during the research process. While listening to the interview recordings, I became aware of my position of coming from an Asian family when I listened to the expression of negative attitudes towards mental illness. My reaction was to believe the lack of understanding about mental illness which was influenced by my previous personal experience with family members. My belief in the views that were expressed may have positively affected the interview process though helping to put the participants at ease to explain their accounts in further detail.

Through reflexivity, I considered the factors in my personal history that triggered my interest in the study. My motivation for the research was linked to a combination of my personal life experience, mental health nursing experience, and my academic role. In relation to my experience of personal life events, my father's death from cancer at the age of 55 in 2006 initiated a huge change in my outlook on life. My father was a strong influential figure in my life and the experience of bereavement helped me to recognise the importance of faith during times of crisis. Whilst considering beginning my PhD studies I reflected upon my religion which had helped me through an immensely difficult time and I questioned if people suffering from mental health problems turned to religion or spiritual beliefs for support in the way that I had. From my previous experience of working as a mental health nurse in an inpatient setting, I had a strong sense

that spiritual needs were not fully addressed in mental health care. Care was prioritised towards the treatment of symptoms and meeting social needs. Why did I not incorporate spirituality into my own practice to help people to get better, particularly when caring for individuals from a wide range of cultural backgrounds? My motivation for the subject area was increased in my role as a university lecturer in which my attention was drawn to the significance of identifying spiritual and religious needs in mental health care. The development of a resource information pack about culture and religion which was intended for use by clinicians led to reflection upon my clinical and personal experience which motivated me to explore the meaning of spiritual care in a mental health nursing context.

Reflexivity was employed through the maintenance of a reflective diary to document thoughts and reflections about the interviews. Clancy (2013: 15; Mann 2016: 18-20) recommend the use of a diary for qualitative research to record thoughts during data collection and analysis as a vehicle for meaningful reflection and focus upon reflexive elements that can shape the interview process and therefore enhance the transparency of the research. Immediately after each interview my initial reflections were recorded. The diary provided a space to record observations, assumptions, concerns, feelings, emotions, and realisations which were reviewed to reflect upon how the interview communication may have been influenced. The notes made explicit my reactions to the interviews which contributed to articulating a subjective awareness and informed the interpretation of the data. Mann (2016: 21-22)

argues that the purpose of recording subjectivity allows the researcher to acknowledge personal experiences, values, professional perspectives and cultural beliefs which may have an impact upon the research process. Maintaining a diary can encourage the researcher to bracket identified preconceptions which have the potential to shape the research. The diary helped to identify areas in which my interpretation of the data may have been influenced by my personal experiences which minimised bias and increased the transparency of the research.

The diary helped me to consider salient aspects of personal identity which may have influenced the power asymmetry during the interview interactions. Mann (2016: 67; Vahasantanan and Saarinen 2012:507) suggest that the individual characteristics of the researcher influences the interaction and the generation of interview data. Factors such as age, gender, race, ethnicity, education and professional background of the interviewer may shape the interview direction and content. During the interviews, my westernised identity through being Asian and British were factors I had to consider as potentially beneficial or problematic characteristics. Darawsheh (2014: 565) suggests that reflexivity involves the self-awareness of the researcher's influence on the participants and the development of rapport. My ethnic background was perhaps beneficial as the participants may have viewed me as having a shared understanding of their backgrounds which could have influenced their willingness to provide information. Alternatively, Edwards and Holland (2013: 77-88) suggest that it is unclear whether research interviews

with people from black and minority ethnic backgrounds benefit from an interviewer who shares a similar background to generate richer data. Even if the ethnic background is shared between the interview and the participant, power asymmetry remains present in the forms of different social status such as education and income. My characteristics could have been problematic in the sense that some participants may have had racial prejudices towards people with an Asian ethnicity. In my role as a member of university staff and a PhD research student, I may have been perceived as arrogant, interfering and from an affluent background. These risks were limited by my honest and transparent approach which involved explaining my roles, my experiences and my motivation for conducting the research. At the time of the interviews I was aged 40 and therefore mature and experienced as a professional which was also perhaps a positive feature in developing a rapport with the participants. My self-analysis included consideration of how I presented my appearance to the participants during the interviews. To minimise the power asymmetry, I paid particular attention to my sense of dress, ensuring that I wore casual clothes to reduce potential intimidation from appearing as a formal person with academic status.

Reflexivity enabled me to reflect upon the impact of my pre-existing knowledge as a mental health nurse on the data collection and analysis. Mann (2016: 73) points to the issue of the researchers' familiarity with the topic which may impact upon the interview. Power dynamics within the interviews are determined by the researcher's position as an insider or outsider to the topic of

interest. The advantage of insider knowledge is perhaps the high level of understanding of the context of the phenomenon. The nursing role can be seen as an insider perspective, enabling the researcher to share a common language and understanding which may improve the rapport with participants and lead to deeper insights. During the interviews my insider experience as a mental health nurse perhaps encouraged participants to talk openly. I was able to draw on my mental health nursing experience to understand experiential accounts of receiving mental health care which enhanced my interpretations of the accounts.

A disadvantage however, is that misinterpretations may arise from the inside knowledge of the topic. Clancy (2013: 14) suggests that a limitation for nurse researchers is the issue of role confusion in which assumptions may be made about processes which are familiar within nursing. The researcher's interpretations are therefore tainted by the nursing perspective, rather than the role of a researcher which may lead to inappropriate conclusions. As I listened to the recordings I became particularly aware of my position as a mental health nurse when listening to the accounts of receiving aspects of mental health care. I felt uncomfortable when the participants expressed negative views about their treatment, thinking about how I recognised these areas of nursing practice. This may have influenced the interpretation of the data as I considered both the participant's perspective and also the clinician's responsibility within the specific situation.

During the data analysis, reflexivity played a critical role. Finlay (2011: 241) highlights the use of personal insight as a platform towards understanding the lived experience which in relation to the research, my personal identity and clinical background in mental health were significant to understanding the lived experiences of participants who were mental health service users making sense of their experiences of spirituality. Reflexivity was included within the initial comments of the transcript, the importance of which is highlighted by Pietkiewicz and Smith (2012: 367; Yardley 2015: 268). The reflective diary was used to record comments during the initial stages of analysis about key aspects in order to avoid rushing into interpretations of the data which is suggested by Shaw (2010: 186-192). The comments were documented and revisited to inform the later process of identifying the themes and interpreting the experience. Certain aspects of the accounts triggered an emotional response therefore the diary was used to record emotional reactions to the interviews. For example, identification with Farida's account of motherhood led to empathy with Farida as a mother. According to Storey (2016: 70-71) personal responses to the data can have positive and negative impacts on the interpretation of the data. A negative aspect is identification with the participant can influence the analysis resulting in the data being shaped to meet the experience of the analyst rather than the participant. In relation to the analysis, there was the risk that the interpretation may have been forced to fit personal experiences of motherhood. Alternatively, a positive aspect of reflection is an inability to identify with the individual may lead to a lack of understanding and empathy which has the potential to create difficulty in achieving the 'insider' perspective

on the topic. Personal reactions to the interviews were acknowledged and discussed during regular supervision sessions with the Director of Studies to monitor how emotions and previous experiences may have influenced the interpretation of the data. The discussions contributed towards attaining a full understanding of the experience and ensured that data had not been overlooked.

A reflexive approach was fostered through using a reflexive diary and discussing the findings with my Director of Studies. I was able to identify other shared experiences with participants which were particularly meaningful and question my thoughts, feelings and reactions which contributed to the analysis and the reduction of subjectivity. The diary helped me to highlight parallels with my personal experience and also acknowledge my reactions to differences between the participants and I. I identified in the diary '*during each interview - the answers to the questions made me think a lot about myself. Just as in the pilot*.' I felt that there was little difference between the participants and I in terms of our values and ways of thinking about religion. I identified with the experience described of parenthood and the experience of bereavement. The reflections and discussion allowed me stand back from my world views to focus my interpretations on what was of significance to the participants, to minimise bias by my perspective.

4.6 Data Analysis

Analysing the data using the IPA framework is detailed and complex (Pietkiewicz & Smith 2012: 366; Reid, Flowers and Larkin 2005: 22). The purpose of IPA analysis is to make sense of the person's world (Langdridge 2007: 110) by stepping into the person's shoes to develop an 'insider's perspective' on the experience (Pietkiewicz & Smith 2012: 366; Reid, Flowers and Larkin 2005: 22). The analysis was intended to provide an interpretation of what spirituality means for these specific people in a specific context. The data analysis involved different levels of interpretation with the intent of making sense of the participants' experiences to answer the research question (Eatough and Smith 2008: 189).

IPA analysis begins with one case and involves six stages which are recommended in a step-by-step guide by Smith, Flowers and Larkin (2012: 82-101). Oxley (2016: 60; Pietkiewicz and Smith 2012: 366; Shaw 2010: 182; Smith and Eatough 2016: 59-64; Smith and Osborn 2015: 39) emphasise the flexibility of the guide which is not intended to be prescriptive but should be adapted to the research. All the stages are completed before moving to the next case which is in line with the idiographic focus of IPA (Smith and Osborn 2015: 39). This section describes the analytic stages which were adopted to enable full immersion in the data which are illustrated in table 4.2.

Table 4.2 Stages of Analysis

Stage	Analysis
1	Reading and re-reading the transcript
2	Initial noting
2a	Descriptive comments
2b	Linguistic comments
2c	Conceptual comments
3	Developing emergent themes
4	Searching for connections across themes
4a	Abstraction
4b	Polarisation
4c	Contextualisation
4d	Function
5	Moving to the next case
6	Looking for patterns across cases

The steps involved reading and re-reading the transcripts, making initial notes, the development of emergent themes, searching across the themes for connections, moving to the next case and finally looking for patterns across the cases. It is essential to demonstrate the breadth and depth of each stage of the analysis to enhance the transparency and trustworthiness of the research (Shaw 2010: 182; Smith, Flowers and Larkin 2012: 182; Yardley 2015: 266). The measures which were taken to increase the quality of the analysis are identified in the next section.

4.6.1 Stages of analysis

Step one: Reading and re-reading

The analysis was performed using hard copies of the interview transcripts. The transcripts were formatted with wide margins to allow space to document comments which is recommended by Langdridge (2007: 110; Smith and Osborn 2015: 84). Data analysis began with the iterative process of reading and re-reading the first transcript with the purpose of becoming immersed in the data (Finlay 2011: 42; Finlay 2014: 126; Oxley 2016: 60; Pietkiewicz and Smith 2012: 367; Shaw 2010: 183; Smith and Eatough 2016: 60; Smith and Osborn 2015: 40; Storey 2016: 70). The close repeated reading of the interview transcript started the process of entering the person's lifeworld, which is supported by Oxley (2016: 60; Smith, Flowers and Larkin 2012: 82).

The first transcript was carefully read while listening to the audio-recording of the interview. To become absorbed in the data, researchers are advised to replay the audio-recording at this initial stage and to imagine hearing the participant's voice during each reading of the transcript (Finlay 2014: 126; Pietkiewicz & Smith 2012: 366; Smith, Flowers and Larkin 2012: 82). Listening to the voice of the person helped with the recollection of the atmosphere of the interview and to visualise the venue in which it took place. New insights were developed with each reading of the transcript and each listening to the interview which is suggested by Oxley (2016: 60; Pietkiewicz and Smith 2012: 366; Smith and Osborn 2015: 40). Specifically, an insight into the understanding of the whole interview structure was developed (Finlay 2014: 126). In addition, richer

sections of the interview were located, and the development of the rapport during the interview were identified with the repeated reading of the transcript which is supported by Smith, Flowers and Larkin (2012: 82).

As part of this stage, first impressions of the transcript were recorded in a reflexive diary alongside the initial recollections of the interview. A summary was written of the person's story to encourage familiarity with the data and to note the initial responses to the participant and the transcript which is suggested by Shaw (2010: 183). Re-reading the data provided the opportunity to understand elements such as the chronology of key events and the connections between certain sections of the interview, all of which were included in the summary. Smith, Flowers and Larkin (2012: 82) state that these measures to record the initial observations enable the researcher to bracket off any judgement and assumptions in order to enhance the focus upon the data.

Step 2: Initial noting

Following the repeated reading of the first transcript in order to gain a general sense of the text, the next stage involved reading the transcript again in greater detail which was achieved by focusing on small sections of data to record initial comments (Shaw 2010: 184). According to Smith and Osborn (2015: 40) the aim of the initial notes is to document the attempt to make sense of what is significant to the participant's experience.

Three analytic tools were employed to make the initial exploratory comments. The tools are not prescriptive but are suggested by Smith Flowers and Larkin (2012: 84; Smith and Osborn 2015: 84) to perform the most detailed level of the analysis. The three stages of noting were; making descriptive comments, linguistic comments and conceptual comments. Three different coloured pens were used to highlight each type of comment, a strategy suggested by Smith and Osborn (2015: 84). The comments were combined on the same transcript to enable the connections to be seen which led to stronger engagement with the data and a deeper immersion in the lifeworld of the participant (Smith and Osborn 2015: 84).

Descriptive comments

Descriptive comments were made which captured the content of what the person had said (Smith and Osborn 2015: 40). Initial comments were made in the right-hand margin of the transcript to organise the data as suggested by Shaw (2010: 184). According to Smith, Flowers and Larkin (2012:84) this stage of note taking involves writing exploratory comments to structure the person's thoughts and experiences with the purpose of compiling a detailed set of notes. The transcript was annotated with any observations of potential significance in response to the words used by the participant (Pietkiewicz and Smith 2012: 367; Smith and Eatough 2016: 59-60; Smith and Osborn 2015: 40; Willig 2013; 87). Observations of meaningful words and phrases, relationships, places, values, descriptions of experiences, emotions and significant events were highlighted and accompanied by written notes

(Smith, Flowers and Larkin 2012: 83). Attention was not only paid to what had been said, but also to the meanings of the nonverbal reactions such as the silences which is supported by Finlay (2014: 136). The intention at this stage was to identify what was happening in specific sections of the text through capturing the meaning of the participant's words. The comments would inform the critical groundwork for the remaining analysis in order to answer the research question, what does spirituality mean to the participants? (Shaw 2010: 187-192). For example, descriptive summaries were documented as 'relationship with God' in the passage in which Bella referred to the feeling that she had no one, other than God (page 52/ line 949). The focus was upon remaining close to the meaning of the text by making descriptive comments about what mattered to the person, rather than making interpretations at this stage (Langdridge 2007: 111; Oxley 2016: 60; Smith, Flowers and Larkin 2012: 83; Smith and Osborn 2015: 40).

The importance of engaging with the data at this stage through the adoption of a phenomenological attitude is discussed by Finlay (2014: 122). The approach encourages curiosity and wonder to reflect upon the pertinent issues in the data and a move beyond what is already known in order to be receptive to new insights (Finlay 2011: 230). Van Manen (2014: 31-32) discusses adopting an attitude of wonder to develop phenomenological reflection rather than simply seeing the data at face value. Embracing a sense of wonder is used to disrupt our taken-for-granted assumptions of the world and involves the researcher taking a step back from the data to nurture a deeper

analysis of the experience. Similarly, the importance of implementing measures to read the transcript at a slower pace is highlighted by Smith, Flowers and Larkin (2012: 82). Complex information is frequently read and summarised quickly which leads to the focus of what is expected to be seen in the data. Consequently, each time the transcript was read, a sheet of blank paper was used to expose four to five lines at a time which prevented a quick and superficial reading of the material. The process facilitated a line by line, word by word analysis which enabled focus upon parts of the whole transcript (Oxley 2016: 60; Smith, Flowers and Larkin 2012: 83). Significant features that were touching, surprising or interesting were questioned with a sense of wonder. Conducting the analysis in this way by writing descriptive summaries of small sections of the content ensured the analysis remained close to the data which is recommended by Shaw (2010: 184). The process enabled detailed consideration to be given to each aspect of the participant's experience.

Time was taken to dwell with sections of the data which allowed hidden meanings to surface. Finlay (2011: 228-230) highlights the role of dwelling to open up the phenomenon and therefore become immersed in the data at this stage of the analysis. Finlay (2014: 125) argues that dwelling revolves around slowing down to pause and linger with small passages of data which helps to magnify the meanings. Shaw (2010: 186) stresses the importance of taking sufficient time to capture the meaning of the content at this initial stage to ensure the analysis is data-driven. The process of dwelling enabled access to a richer and deeper engagement in the analysis by reliving what was said in the

description of the experience. Finlay (2011: 230; Finlay 2014: 126) recommends the application of lifeworld questions when dwelling with the data to encourage remaining with the data rather than prematurely moving to theory and interpretation. Questions were asked during the analysis which included, what does it mean to be this person? Where does he/she experience his/her day? Are some places safer than others? Who are the significant people in the person's life? Is there a mood or tone attached to the person's account? What is this experience like? Such questions enabled dwelling with the data to discover different meanings in the experiential account and therefore a deeper analysis.

Writing the descriptive summaries began to illustrate what spirituality meant to the participants. Each participant's account of their experience was acknowledged as 'their truth' rather than judged, which Finlay (2014: 123) highlights is an important element of the analysis. The focus of the analysis was to accept the participant's description of their spirituality and to pay close attention to the meaning of the experience to the person.

Linguistic comments

The second stage of making exploratory comments involved recording linguistic comments which focused upon the use of language in the transcript (Oxley 2016: 60; Smith, Flowers and Larkin 2012: 83; Smith and Osborn 2015: 40; Willig 2013: 87). Each line of the transcript was read to question the meanings of words and sentences (Smith and Osborn 2015: 84). Observations

were highlighted and documented in the right-hand margin on the specific features of language highlighted by Finlay (2014: 126; Pietkiewicz and Smith 2012: 367) such as laughter, pauses, intonation, emphasis, repetition, tone of voice and metaphors. In addition, the use of pronouns, and the fluency of the speech such as signs of hesitancy were identified as suggested by Smith, Flowers and Larkin (2012: 88). An example of the linguistic commentary is highlighted in Claire's account (page 7/ lines 150-164). Claire's description of her involvement in a road accident and the start of her mental illness included repetition of 'sort of erm' which indicated hesitancy in her speech.

Conceptual comments

This stage of analysis involved working with the data at a deeper interrogative level, which is in line with the guidance from Oxley (2016: 60; Smith, Flowers and Larkin 2012: 84). The transcript was annotated with questions which were prompted by significant features on the context of the data. Questions such as 'How does this make her feel?' in relation to Martha's description of protection from God, prompted further questions and a shift from the specific meaning of protection towards understanding a sense of safety (page 12/lines 262-273). Smith, Flowers and Larkin (2012:88) state that this level of analysis is more interpretative than the previous stages of annotation with the purpose of exploring a variety of meanings. Time must be allowed at this stage for personal reflection as the interpretations will be influenced by the experiences and knowledge of the researcher. The researcher is encouraged to be as questioning as possible in order to move the analysis from descriptive

to interpretative whilst ensuring the interpretation originates from the actual words used by the participant.

Deconstruction

This strategy was used to illuminate specific words and meanings in the transcript. Deconstruction of the text is suggested by Smith, Flowers and Larkin (2012: 90) as a method to further avoid the superficial reading of the data. Each sentence was read backwards, taking one paragraph at a time to interrupt the flow of the interview. The analysis allowed specific focus upon what was actually being said by the individual which led to a deeper understanding of the participant's world. The approach helped to discover meanings which had been overlooked during previous readings of the transcript. For example, in Farida's account, the approach helped to deconstruct the sentence 'and you don't want people looking' (page 45/line 845). Attention was drawn to the word 'looking' in the context of people looking at Farida because of her religion and ethnicity. The focus on the use of the word facilitated a closer understanding of what Farida was saying about the impact of feeling uncomfortable as the object of attention and judgement by others.

Step 3: Developing emergent themes

At this stage the written notes from step 2 became the primary focus of the next level of the analysis, rather than the transcript (Pietkiewicz and Smith 2012: 367; Smith, Flowers and Larkin 2012: 91). The aim was to reduce the volume of data from the initial notes whilst retaining the complex details by

searching for relationships, patterns and connections in the annotations (Smith, Flowers and Larkin 2012: 91). Emergent themes were identified by returning to the start of the transcript to systematically develop concise phrases which characterised sections of the initial notes (Finlay 2011: 142; Willig 2013: 88; Smith and Osborn 2015: 41). The themes were recorded on the left-hand margin of the transcript (Langdridge 2007: 111; Smith and Eatough 2016: 61; Smith and Osborn 2015: 41; Storey 2016: 72). It was essential that the themes captured what was important in the exploratory comments and were underpinned by both the description of the participant's words and the interpretative elements of the analysis (Smith, Flowers and Larkin 2012: 92; Smith and Osborn 2015: 41). Finlay (2014: 136-137; Willig 2013: 88) stress that the importance at this stage is to retain focus on the meaning of experience of the phenomenon, rather than simply listing themes. The themes were questioned therefore to determine 'what does this mean for the lived experience of spirituality for this person?' A useful strategy suggested by Finlay (2014: 137) was to ask, 'what three things about the lived experience as a whole stand out for you?' The technique enabled a greater focus towards what was significant in the transcript. For example, a theme that emerged from Farida's account was 'loss of identity' (page 10/lines 168-170). The theme titles were abstract phrases which remained closely linked to the data (Pietkiewicz and Smith 2012; 367). Shaw (2010: 194-195) highlights the idiographic focus of the analysis. The emergent themes were specific to the participant which is in line with the commitment of IPA to understanding experience from the perspective of the experiencer.

Step 4: Searching for connections across emergent themes

Shaw (2010: 196) identifies that the aim of this stage is to search for shared themes across the experiential account to develop an understanding of the participant's experience. The emergent themes were typed as a list in chronological order before looking for connections (Langdridge 2007: 111; Pietkiewicz and Smith 2012: 368; Smith, Flowers and Larkin 2012: 92; Smith and Osborn 2015: 42). Where common links were identified between themes, the themes were moved to develop clusters of themes with the intention of providing structure to the analysis and reducing the data (Biggerstaff and Thompson 2008: 218; Oxley 2016: 60; Shaw 2010: 196; Smith and Eatough 2016: 61; Willig 2013: 88). A number of different ways were used to organise the connections between themes which Smith, Flowers and Larkin (2012: 99) suggest rather than prescribe to drive the analysis to a deeper level. Each method within this stage involved moving back and forth to revisit the transcript to ensure the themes represented the original text (Langdridge 2007: 110; Willig 2013: 88). The following strategies of abstraction, polarisation, contextualisation and function were employed to develop clusters of themes to create an understanding about what spirituality means to the individual.

Abstraction

Smith, Flowers and Larkin (2012: 96) describe abstraction as grouping similar emergent themes together with the purpose of developing a super-ordinate theme. Clusters of themes were moved together and labelled with a title that captured the meaning of the experience which is recommended by

Willig (2013: 88). For example, there were a number of similar themes around 'Relationship between spirituality and religion' in Thomas' account which were grouped together under the super-ordinate theme title 'The Meaning of Spirituality'.

Polarisation

The emergent themes were explored to identify differences in terms of oppositional relationships (Smith, Flowers and Larkin 2012: 97). The opposing themes were presented in a table (see example in appendix 8) which developed the analysis at a higher level by highlighting connections and contradictions within the person's experience. For example, a number of negative elements of Bella's experience such as loneliness were identified alongside positive aspects such as companionship. The oppositional relationships provided another means for organising the data.

Contextualisation

Connections were identified between the emergent themes through the process of contextualisation. At this stage of the analysis, attention was paid to the context of the emergent themes such as major life events, time and cultural influences. Themes were linked to a series of key events for example within Claire's account, the onset of physical illness and the onset of mental illness (see example in appendix 9). Smith, Flowers and Larkin (2012: 98) indicate that such information may be spread across the transcript therefore applying

contextualisation to the data enables the researcher to organise the information resulting in a deeper interpretation.

Function

The analysis at this stage unlocked a deeper interpretation of the account as the focus moved towards identifying the specific function of the emergent themes (Smith, Flowers and Larkin 2012: 99). The function of the participant's words is interwoven with the meaning of the participant's experience. The themes were considered in terms of how they were used to present the person in the interview for example, 'Love from God' suggested Martha was positioned with a sense of acceptance within her experience (see appendix 10). A record of each stage of the above analysis process was maintained in a research diary.

Bringing it together

The next stage of the analysis involved the creation of a summary table to clearly illustrate the development of the super-ordinate themes and the emergent themes. Smith and Eatough (2016: 62) argue that the table represents the iterative analysis of moving back and forth during each stage in order to preserve the integrity of the participant's words. For example, an examination of the themes within Bella's account led to the development of four clusters of themes which captured the central meaning of spirituality to Bella. The table of themes included the page, line number and a meaningful extract from the transcript to easily locate the theme (Langdridge 2007: 110;

Pietkiewicz and Smith 2012: 368; Shaw 2010: 198; Smith, Flowers and Larkin 2012: 99; Smith and Osborn 2015: 45; Storey 2016: 75; Willig 2013: 88).

A mind map diagram was also developed to enable a coherent understanding of the complex connections and patterns between the super-ordinate themes and the emergent themes for each participant (see example in appendix 11). Smith, Flowers and Larkin (2012: 99) highlight that a creative representation of the themes in different ways can move the analysis towards a deeper level of interpretation. In addition, files were created for each emergent theme which is recommended by Shaw (2010: 198) to enhance writing up the results of the analysis. Each file was labeled with the title of the specific emergent theme and contained all the key words, phrases and line numbers from the original transcript which related to the theme (Smith and Osborn 2015: 45). According to Smith, Flowers and Larkin (2012: 99), undertaking this process assists with reviewing the internal consistency of each theme.

Step 5: Moving to the next case

When the analysis of the first transcript had been completed, the above process of steps one to four were repeated with the next transcript which is suggested by Langdridge (2007: 110; Shaw 2010: 198; Smith, Flowers and Larkin 2012: 100). Due to the idiographic commitment of IPA research, Smith, Flowers and Larkin (2012: 100; Smith and Osborn 2015: 45) state the importance of bracketing the themes which emerged from the first transcript before beginning to analyse the next case in order to do justice to the individual

experience. Finlay (2011: 142) argues that the primary concern is to examine the next transcript with a fresh perspective to respect its individuality which will enable the discovery of new themes with each participant. The systematic process of analysis was repeated for each subsequent case. A separate summary table of superordinate themes was produced for each transcript.

Step 6: Looking for patterns across cases

This final stage of the analysis was conducted utilising all the cases together. The cases were integrated by examining the summary tables of themes for each participant, an approach identified by Willig (2013: 91) to gain an overall understanding of the meaning of spirituality. Connections, similarities and patterns of themes were examined across all the cases as a whole. Finlay (2011: 142; Smith, Flowers and Larkin 2012: 101) suggest searching for the themes which are the most dominant, whilst also recording idiosyncratic qualities. In addition, consideration was given to understand how a theme in one case may unlock a theme in a different case (Oxley 2016: 60). As the analysis deepened, the process involved a relabelling of themes, a creative step which is identified by Smith, Flowers and Larkin (2012: 101). The emerging final themes were systematically checked against the transcripts, the importance of which is highlighted by Willig (2013: 91) to ensure a close connection with the original data. The intent of high quality IPA is to represent the individual qualities of each person's experience but also the shared qualities across the whole group. The outcome of this analysis is presented as a master table to illustrate the super-ordinate themes and the relevant emergent themes

across the cases to represent the shared experience of spirituality (Biggerstaff and Thompson 2008: 218; Smith and Eatough 2016: 62; Smith and Osborn 2015: 46). Key words from each participant are identified with page and line numbers to ensure the themes are grounded in the data. The length of time that was taken to complete the analysis from steps 1 to 6 is illustrated in the table below.

Table 4.3: Gantt chart to illustrate the time taken to complete the analysis.

Transcript	**March 2016**	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2017**
5	✓	✓	✓								
4				✓	✓						
3						✓	✓				
2								✓	✓		
1										✓	
Master table											✓

It is recognised that the analysis process continues during the writing up of the results (Smith and Eatough 2016: 48-62). Writing encouraged reflection on the findings and therefore deepened the analysis of the experiential accounts. The themes were examined with illustrative extracts which enhanced the level of interpretation.

4.7 Assessing the Quality of the Research Methods

The quality of the research process was maintained in a number of ways. Yardley (2015: 257) suggests that research validity is concerned with the legitimacy of the study and is evaluated by considering factors in how the research has been conducted and the trustworthiness of the findings. Four

principles are identified by Yardley (2000) for demonstrating the validity and assessing the quality of research. The first principle is the demonstration of sensitivity to context which was evident in various stages of the study. Sensitivity to the theoretical context of the research is essential to developing the methodology (Langdridge 2007: 156; Yardley 2015: 265). In IPA research, relevant literature is used to initiate the study while the discussion relates the findings to literature which may not have been identified at the beginning of the research (Smith, Flowers and Larkin 2012: 181). Sensitivity to context was shown in the exploration of the literature concerning spirituality and mental health, IPA theory and the underpinning philosophy.

In addition, Yardley (2015: 265) points out that qualitative research demands sensitivity towards the perspective and socio-cultural context of the participants. At the data collection stage, the impact of the researcher upon the interview dynamics, the rapport and the balance of power was considered through a reflexive approach. The influence of the interview setting upon the participants was considered to enable the interviewees to feel at ease. Smith, Flowers and Larkin (2012: 180) argue that the production of a good interview is indicative of the skills required to demonstrate sensitivity to context. Efforts were made during the interviews to empathise with the participants, to help the participants to feel comfortable and to address the power inequalities between the researcher and the participants. The interview techniques that were employed such as open-ended questions enabled the participants to speak freely about their concerns which manifested sensitivity to their perspectives.

Sensitivity to context was manifested during the process of data analysis. Yardley (2015: 266) suggests that sensitivity towards the socio-cultural context continues at this stage of the research in relation to how the views may or may not be expressed. Each participant was considered in relation to their cultural background and ethnicity when analysing their experience. Sensitivity to the data was also demonstrated through the careful presentation of the findings to illustrate that the themes were data driven. A number of extracts from the recorded interviews were used to give a voice to each participant and to support the findings. Immersion in the data was achieved with each step of the line by line analysis which was central to learning the complexities of how each participant made sense of their experience (Smith, Flowers and Larkin 2012: 180). The interpretations were appropriate to the sample and are presented as possible claims rather than findings which can be generalised as a demonstration of sensitivity towards the perspectives of the participants.

The second principle which indicates research validity is commitment and rigour. The rigour or thoroughness of the study was shown in the careful selection of an appropriate sample in relation to the research question. Considerable commitment was made when conducting the interviews which is in line with the demonstration of sensitivity to context. Commitment was demonstrated in the close attention paid to the participants to ensure they felt at ease and to listen closely to the content of their speech. Rigour and commitment were shown in the skills required to conduct in-depth interviews.

Careful listening was used to identify cues from the participant and probing questions were asked to gain a deeper insight into the experiential account.

Commitment and rigour continued in the data analysis. Yardley (2015: 266) highlights the role of this principle is to demonstrate that the analysis has been conducted with sufficient depth to provide new knowledge rather than simply presenting parts of the data. Rigour and commitment were shown in the personal commitment that was invested to conduct the detailed case by case analysis which was thorough and systematic. Rigour was demonstrated in the interpretative analysis which aimed to go beyond description of the experiences. Presentation of the analysis showed rigour and commitment in the careful selection of the proportionate range of interview extracts to illustrate the themes. Yardley (2015: 267) suggests extensive engagement with the data is a demonstration of commitment and rigour. Supervision was used to achieve rigour which is supported by Smith, Flowers and Larkin (2012: 181). The research design, the data collection and the analysis were regularly discussed with the Director of Studies to ensure a rigorous approach. Prior to data collection, IPA training was attended at Aston University in 2014 which helped to develop my understanding of IPA research. During data collection and analysis I attended IPA discussion groups and used the IPA yahoo forum which helped to clarify my thoughts about the research and enhance the rigour of the study.

The third principle is transparency and coherence. Yardley (2015: 267) states that coherence refers to the extent to which the research makes sense which is determined by the clarity of the arguments supporting the purpose of the study, the research methods and the data analysis. Coherence and transparency were enhanced in the careful writing of the findings supported by a range of quotations to present the themes in a clear and logical order for the development of powerful arguments. An in-depth understanding of the principles of IPA research helped to coherently select appropriate methods. The study has maintained its commitment to IPA rather than following the procedures of other qualitative approaches. The focus in the writing is upon the lived experience of spirituality and the coherence with IPA has continued in the presentation of the findings which are reported as interpretations of experiences rather than generalised outcomes.

Transparency of the research is concerned with how clearly the research is reported and justified (Yardley 2015: 268). Transparency was established in the detailed writing up of each stage of the research. Attempts were made to enhance transparency through the description of the sample selection, the process of conducting the interviews and the detailed account of each stage of the data analysis. Smith, Flowers and Larkin (2012: 183) identify an independent audit as a procedure to enhance research validity. An information trail was maintained which consisted of the interview schedule, the audio recordings of the interviews, the annotated transcriptions of the interviews, the tables created at each stage of the analysis and the reflective diary to

demonstrate the interpretations were an accurate reflection of the original data (Yardley 2015: 264-268). The purpose of the independent audit is to monitor the transparent and systematic development of the findings. One of the ways in which the independent audit can be conducted is through the supervisor of the research. In line with this approach to enhance the transparency and coherence of the research, each annotated transcript and table of themes was discussed with the Director of Studies to ensure that the development of each theme was grounded in the data. Ideas were shared about the salient features of each transcript to develop my interpretative skills. The reflexive analysis was discussed to consider the specific features of the study which may have been influenced by my personal characteristics. The paper trail provides a clear account of the decisions and procedures which is a strong indicator of the quality of the research.

The fourth principle is impact and importance which relates to the potential of the research findings to make a practical difference to society which is achieved by building upon existing knowledge (Yardley 2015: 268). Impact and importance are demonstrated in chapter six in which the recommendations for mental health practice, nursing education and policy are considered.

Triangulation is a method that can be used to enhance the quality of the research in relation to impact and importance. Yardley (2015: 261-263) suggests that triangulation involves seeking the perspective of other researchers to enrich the process of data analysis. The emerging themes were

regularly discussed in supervision meetings with the Director of Studies to view the data from different perspectives. The initial comments and themes were checked for their validity in relation to the original text. Each mind map and table of themes was discussed alongside the interpretative commentary for each transcript which ensured the analysis was systematic and transparent, a process which links to the independent audit to enhance the validity of the research (Smith, Flowers and Larkin 2012: 184). In addition, transcript extracts were read and interpretations were shared with fellow researchers at the regional West Midlands IPA group, and with IPA researchers within the university. These discussions helped to improve the clarity of the analysis and ensured the identification of all potential themes and interpretations. Yardley (2015: 263) argues that these steps enhance the quality of the analysis by ensuring that the findings are meaningful to others and are not restricted to one point of view. Triangulation of these perspectives ensured that the analysis made sense to others and helped to both identify and clarify complex themes which enhanced the coherence of the research.

Consideration was given to the value of member checking as a method to enhance the quality of the analysis. It can be argued that confirmation of the findings with the participants strengthens the credibility of the research to safeguard against misrepresentation of the findings (Finlay 2011: 222-223). Yardley (2015: 263) however, suggests that it is not always appropriate to request feedback from participants to comment on the analysis. Before seeking feedback, consideration should be given to whether the themes will be

understood by the person, and the constructive nature of the feedback. Larkin and Thompson (2012: 112) suggest the request for participant feedback may be counter-productive due to the interpretative nature of IPA research therefore, my interpretations of the data may have been difficult for the participants to comprehend.

An additional consideration was the length of time that had passed from conducting the interviews to completion of the analysis. Finlay (2011: 223) argues that what may have been disclosed at the time of the interview as their 'truth', may be not be recalled by the participant at a later date and it may be difficult for the person to remember the specific context of the interview. Given the duration of twelve months between the interviews and the development of themes, the participants may have struggled to remember the details of their account. Furthermore, the analysis may have brought emotive topics to the surface therefore seeking feedback carried the risk of causing further distress to the participants. Other possible ethical issues may have arisen from seeking participant feedback on the transcripts. Mero-Jaffe (2011: 240-243) identifies the risk of causing reactions of embarrassment for the participants as a result of exposure to the content and the way in which spoken language is presented. The transcripts contained all the sounds of hesitant speech, pauses and laughter which disrupted the flow of the written language and may have led to the participants finding the transcripts difficult to read and feeling uncomfortable about their fractured speech. For these reasons, careful consideration was

given to the decision against engagement in participant validation and the transcripts were not sent to the participants to review for accuracy.

Conclusions

This chapter has provided a detailed account of the methods used to conduct the research. The role of service user involvement within the research design has been discussed followed by the ethical issues of the research. The data collection and analysis has been examined, including the steps taken to increase the quality of the study. The following chapter will present the research findings beginning with an explanation of the format for the presentation of the IPA themes.

Chapter 5

Findings

In this chapter I present the findings from the research. Firstly, the research participants are introduced. In order to understand how spirituality is understood by each person, it is necessary to have an insight into the context of the participants' lives. Secondly, the format for the presentation of the findings and discussion is explained whereby the findings section is presented separately from the discussion chapter. The organisation of the themes and the use of supporting extracts from the data will be discussed. Finally, the themes from the analysis are presented.

5.1 The Research Participants

IPA is an idiographic approach which means a focus on the particular (Pietkiewicz and Smith 2012: 363). The idiographic commitment concentrates upon understanding phenomena from the perspective of a particular person within a particular context (Finlay 2011: 140; Smith, Flowers and Larkin 2012: 29). Understanding the person-in-context involves positioning the initial account in relation to the wider social and cultural issues (Larkin, Watts and Clifton 2006: 109). In order to give a voice to each specific experience of spirituality and mental health, it is therefore essential to understand the unique circumstances of each person. The following section provides an outline of the participants. Pseudonym names have been given to each individual to maintain

confidentiality. Table 5.1 provides a summary of the participants' demographic information.

Table 5.1: Participants' demographics

Participant	Date of interview	Age	Gender	Ethnicity	Spiritual beliefs
1. Farida	19.3.15	30	Female	British Pakistani	Islam
2. Bella	10.4.15	30s	Female	Black British, Caribbean	Christianity
3. Thomas	10.4.15	49	Male	Black British	Christianity
4. Martha	16.4.15	64	Female	Jamaican	Christianity
5. Claire	16.4.15	44	Female	Mixed Caribbean, English	Born Again Christian

Participant 1: Farida

At the time of study Farida was 30 years old. Her ethnic background is British Pakistani, her religion is Islam and she was raised in a Muslim family in the UK. She is married and has a young daughter and she describes a lack of support during her pregnancy as she struggled to bond with her baby. Farida suffers from depression and in addition, her father has suffered from depression since Farida was a child. Farida describes feeling uncomfortable about attitudes towards her ethnicity and her religion in group settings. Farida describes negative attitudes towards mental illness within the Asian culture and consequently, she hasn't told anyone in her family that she has a mental illness and is receiving help. Farida was attending a community mental health support group at the time of the study.

Participant 2: Bella

At the time of the interview Bella was in her 30s. She is from a Black British, Caribbean background. Bella is one of four children and she was raised as a Rastafarian by her mother. As a child Bella questioned her mother's beliefs and later became a Christian. She describes experiencing abuse during her childhood. Bella experiences hallucinations, depression and she self-harmed at the age of 18. Bella has experience of hospital admission for her mental illness. Bella writes poetry and has participated in setting up a community mental health support group for people who experience hearing voices, of which she is a member. On the day of the interview, Bella arrived with typed notes about her thoughts on the topic that she had specifically prepared to present.

Participant 3: Thomas

Thomas was 49 years old at the time of the study. His ethnicity is Black British, and his religion is Christianity. Thomas is married with children and he doesn't discuss his spirituality with his family. Thomas has experience of being sedated and detained in hospital under the Mental Health Act, to receive treatment for his mental illness. Thomas has experienced hallucinations and in the past he has been suicidal. At the time of the interview, Thomas was attending a community mental health support group for people who hear voices.

Participant 4: Martha

At the time of the interview, Martha was 64 years old. She is Jamaican, and her religion is Christianity. She is a mother to four children. Martha was raised in a Christian family in Jamaica. She describes a strict upbringing and she attended Church every Sunday. Martha was living in the UK at the age of 26. She struggled financially when she was raising her children and now her children are fully grown and in employment. She had a near death experience when she was physically unwell in hospital. Martha has experience of hospital admission to receive treatment for her mental illness and she has suffered from depression. At the time of study, Martha was attending a community mental health support group for people who hear voices.

Participant 5: Claire

Claire was 44 years old at the time of the interview. She is from a mixed Caribbean and English background. As a child, Claire didn't have a faith and now she is a Born-Again Christian. Claire prays regularly, and she reads a religious booklet every day for advice. Claire had the booklet in her handbag on the day of the interview. Claire also uses a prayer telephone line and watches Christian television channels. Claire started praying when she was aged 18-19, which followed an incident whereby she was the victim of a road accident and she thought she was going to die. Claire's spirituality includes her poetry writing, song writing and running in her local park. Claire describes little family support and her family don't know about her spiritual beliefs. Claire became mentally unwell due to the experience of bullying and racism at work. She has

experience of receiving treatment in hospital for her mental illness. At the time of study, Claire was attending a community mental health support group for people who hear voices.

Summary

This section of the findings chapter has provided an outline to introduce each of the participants. The next section explains the presentation format of the findings.

5.2 The Separation of the Results from the Discussion

The primary focus of the results section is to present an account of what has been learnt about the participants' experiences of spirituality. From an idiographic perspective, the analysis is committed to the individual experience without referring to specific theory. Smith (2004: 45) recommends the interpretative analysis should not be informed by the pre-existing wider literature. This structure is in line with the suggestion of Pietkiewicz and Smith (2012: 369; Smith, Flowers and Larkin 2012: 112-113) who advise the separation of the discussion from the analysis. The identified themes should be discussed in the context of the theory in the discussion section (Smith 2004: 45; Smith, Flowers and Larkin 2012: 112). The discussion section will follow to position the results in a wider context with reference to the literature.

5.2.1 Presentation of the themes

The findings are structured around the super-ordinate themes and emergent themes. The super-ordinate themes capture the main concerns of the participants (Shaw 2010: 197-200). Biggerstaff and Thompson (2008: 218) recommend that specific care is taken in IPA to select the extracts from the interviews which best represent the experience of the participants and illustrate how each theme is manifested in the interview transcripts. The final themes are summarised within a table which includes supporting extracts from the data. The presentation of a summary table is the norm in IPA (Biggerstaff and Thompson 2008: 218; Pietkiewicz and Smith 2012: 369; Reid, Flowers and Larkin 2005: 23; Smith, Flowers and Larkin 2012: 109; Willig 2013: 89). The quotations are labelled with the participant pseudonym name, the page and line number from the interview transcripts. Pietkiewicz and Smith (2012: 368; Willig 2013: 91) highlight the benefit of this structure which enables the reader to identify the exact location of the extract within the context of the transcript. The table of themes provides the focus for the presentation of the analysis.

5.2.2 The use of quotations

Each super-ordinate theme and the corresponding emergent themes will be presented in turn. The results are organised around an introduction of the theme which is supported by evidence from the participants' interview transcripts to illustrate the individual stories. Using verbatim extracts retains the voice of the personal experience which is a key focus of IPA (Hefferon and Gil-Rodriguez 2011: 758; Pietkiewicz and Smith 2012: 369; Reid, Flowers and

Larkin 2005: 22). Finlay (2014: 135-137) suggests the purpose of each quotation is to capture the particular experience to support a rich and meaningful description of the phenomenon. Language, Willig (2013: 94) argues, is the essential tool for each participant to communicate their experience. The process of analysis involves interpreting how the words are used to understand the phenomenon which is highlighted by Van Manen (2014: 390). The results therefore focus upon the role of language in each extract to understand the experience of spirituality. The extracts from the data are embedded in the findings to illustrate the transparency of the themes.

5.2.3 Presentation of Interpretative analysis

Each excerpt from the interviews is directly followed by the analysis which Smith (2011: 24) argues should be interpretative, not descriptive. By presenting the findings in this way, Shaw (2010: 199-200; Smith 2011: 24) argues the results convey the relationship between each data extract and the theme. Smith (2011: 24) highlights the process is evidence of the double hermeneutic which is an attempt to make sense of the participant who is attempting to make sense of their experience. A clear distinction is made between each extract and the interpretative commentary, the importance of which is stated by Hefferon and Gil-Rodriguez (2011: 758; Smith and Osborn 2015: 49; Willig 2013: 92).

According to Smith (2011: 10) the guidelines for good IPA studies recommend a balanced presentation of themes to identify the levels of similarity and difference within each theme, known as convergence and divergence. The

findings should not only represent the themes that are shared by the participants but also clearly illustrate the idiographic perspective by the distinct ways in which the themes manifest specifically for individuals (Reid, Flowers and Larkin 2005: 20). Hefferon and Gil-Rodriguez (2011: 758) suggest interweaving the accounts of the participants to illustrate both the individual and the group experience. The extracts are selected to represent the patterns of shared experiences within each theme alongside the experiences which are unique to each participant. Smith (2011: 24) highlights the importance of demonstrating rigour in the results by providing a range of evidence for the prevalence and variation of each theme. Data extracts are therefore presented from half of the participants for each theme which is in line with the recommendation for the sample size of four to eight participants (Smith 2011: 24).

5.2.4 Reflexivity within the analysis

The issue of reflexivity is addressed in the results chapter. It is argued to be best practice to acknowledge preconceptions and beliefs during the process of data analysis to enhance the transparency of the findings (Brocki and Wearden 2006:101, Langdridge 2007:58-61, Willig 2013:92). Personal reflections are therefore embedded within the results to demonstrate the process of analysis.

Summary

The format for the structure of the results section has been presented. The next section of this chapter will present the findings of the research in the form of the IPA themes.

5.3 IPA Findings

I completed the interpretative analysis and the identification of the themes before I conducted the in-depth literature review, which was presented in Chapter 2, to prevent influence of the pre-existing literature. The analysis produced three super-ordinate themes to illustrate the powerful meaning of spirituality to each participant. The first theme explores how spirituality is understood by the participants in terms of religion and broader concepts. Positive features and negative aspects are recognised within the meaning of spirituality therefore, the relationship with spirituality is one which is controlled and adapted according to the wellbeing of the person. The second theme examines the ways in which spirituality helps each person to cope with a sense of loss in relation to living with disempowerment and isolation. The third theme addresses the role of spirituality in providing a sense of fulfilment. A sense of security and purpose from spirituality enables the participants to feel whole. Seven emergent themes have been identified within the super-ordinate themes. The following table provides a simplified presentation of the findings in which each super-ordinate theme is identified alongside the corresponding emergent themes. The titles of the emergent themes contain the words of the participants to remain close to their experiences.

Table 5.2 Table of Themes for All Cases

Super-ordinate Themes	Emergent Themes
a. Controlled relationship with spirituality	*The things that are important to me: The meaning of spirituality*
	I'm not handling it well: Negative effects of spirituality
b. Experience of loss	*I'm in turmoil: Living with disempowerment*
	No one can understand you: Living with isolation and judgement
c. Feel like a whole person	*It's God's protection: A sense of security*
	Keep level headed: A sense of control
	Helped me to identify who I was: A sense of purpose

The findings clearly demonstrate the strong relationship between spirituality and mental health. A detailed table of the results will be provided at the end of the chapter to present a summary of the whole analysis. The following sections will explore each super-ordinate theme and the associated emergent themes in detail. Reflexive comments will be included in the analysis as required. Specific notations have been used in the transcript extracts to improve the flow of the narrative which are explained below:

Key: **[ ]** *to symbolize material omitted such as minimal prompts used by the interviewer*

… *to identify a significant pause*

[mental health support group] *explanatory material added to the extract to increase the understanding of the context.*

The next section examines the relationship between the participants and their spiritual beliefs.

5.4 Super-ordinate theme a. Controlled relationship with spirituality

Spiritual needs are both complex and specific to the individual person. The relationship with spirituality is not one which is static and therefore an attempt is made by the participants to manage the spiritual connection. The meaning of spirituality varies and includes both positive and negative aspects. The following emergent theme examines what spirituality means to the participants.

5.4.1 Emergent theme: The things that are important to me: The meaning of spirituality

Religion is significant to all of the participants in their understanding of spirituality. The accounts capture a complex relationship between religion and the experience of illness as it appears that religion becomes important during periods ill health. Martha explains how she was drawn towards religion following her experience of serious physical health problems.

> "I've been sick in the hospital, blood clot went to my lungs. [ ] The doctor send to my children [ ] that was living with me at the time, [ ] they send and told my child's father, that, you know, I'm dying and they came to the hospital. And I remember at that time, I wasn't a Christian yet. But my sister was a Christian. [ ] My sister prayed for me and some of the other Church people that I knew, the lady that took me to this Church that I got converted in. [ ] And they prayed for me. And I remember when I heard the doctor. So I know that God has got a mark on me. [ ] I remember when I heard the doctor say. The nurses when

> they came over, the nurse one of the nurse said to the other nurse, the doctors did all they could for her didn't they, [ ] because they thought I was dead. And at that time I was comin around, and all I just shout and said 'I can hear you but I can't see ya' .[ ] And when I said that now [ ] they called the doctors and they come around me [ ] and they were, putting their fingers up and said like 'how many fingers' and and gradually until I come around. So I know God was with me. You know and from that time, [ ] that was what helped me as well to, to become a Christian. [ ] Because I just said you know, God was so good to me. [ ] Because I I I I passed out when I died, and God brought me back. So I said well I shouldn't beat the word doing these things, [ ] of the word I should be serving [ ] God because he was good to me. So I prove, I've proven God many times."
>
> (*Martha, pages 15-17/ lines 334-372)*

For Martha, two major objects of importance are Christianity and her belief that her life was saved by God. Her reference to being 'brought back' highlights Martha's reflection on the fragility of life. Martha feels protected by God and believes that she was given a second chance to live which has an impact on her feeling of self-worth. Reflecting on this I recalled a similar experience with a family member who was seriously ill which helped me to understand Martha's account. The words 'I know that God has got a mark on me' illustrates the personal connection Martha feels with God. Martha stutters during her account which reflects the great significance of the event. She appears to have experienced a transformation within herself which changes her outlook on life and strengthens her views on her religion. God's kindness towards Martha in the words 'he was good to me' is a recurring belief throughout Martha's account. God's unconditional love for Martha underpins her thinking about spirituality and religion which she explains in the following extract.

> "I feel good. Yeah because I know that you know, I I felt that somebody loves me. It doesn't matter what people would say

> or what people will do. I encourage myself [ ] that a server and God [ ] who watches over me [ ] and who cares for me. [ ] So you know I have that inner peace."
>
> *(Martha, page 29/ lines 649-665)*

The meaning of spirituality for Martha appears to comprise compassion from God and 'inner peace' which she feels to such an extent that it must be acknowledged as a key element of her lifeworld.

The sense of ill health leading to the development of religious belief is echoed in Claire's account whereby she shares an experience of physical ill health which has drawn her closer towards religion. Claire explains:

> "I suppose I first started praying I would say probably when I was about 18-19, 'cause I got knocked down by a motorbike [LAUGHS] [ ] and I thought I was gonna die. [ ] And from that time, I started to sort of, pray, just generally just pray to be grateful to be alive."
>
> *(Claire, page 7/ lines 150-156)*

Similar to Martha, an awareness of the value of life leads Claire to seek solace in religion. Claire identifies herself as a Born Again Christian, in which her beliefs are not only defined by her physical trauma, but also strengthened by the onset of her mental illness. Claire says:

> "I think there's something to do with being, becoming mentally unwell [ ] and spirituality that, [ ] it's like you open a door to [ ] like the higher power or whatever, [ ] and because you're ill, [ ] you believe more that that you're sort of erm, closer to that higher power."
>
> *(Claire, page 17/ lines 401-411)*

The extract appears to suggest Claire's spiritual beliefs are a significant source of support in the context of mental ill health. Claire's reference to a 'higher power' illuminates that while religion is important to Claire, her

understanding of spirituality is broader than her belief in God. Claire describes the 'closer' connection to her spirituality through being unwell which highlights her understanding of her vulnerability and her greater need for support. On reflection I drew on personal experience of a family member who stated feeling closer to God during serious illness which enhanced my understanding of Claire's connection. Claire was the victim of bullying and racial prejudice which led to the development of her mental health problems. Consequently, the feeling of support bears strong significance for Claire when living with the uncertainty and fear that is associated with abuse and mental illness.

For some participants, spirituality is defined by the act of praying. It appears that praying functions as support for mental illness and a way in which to communicate distress. Bella is a Christian and explains her need for prayers when she is feeling unwell.

> "Them to, have a Christian who who's working there, to be able to pray for me. Or ask somebody, do you need somebody to pray for yah? [ ] D'ya know what I mean? [ ]That's it, just to ask for prayer. [ ] Yeah, I'm not asking for much."
>
> *(Bella, pages 32-33/ lines 590-597)*

At times of distress, what appears to be important to Bella is the knowledge that somebody is praying to God for support on her behalf. Bella expresses a need to know that she has not been forgotten by others, rather that she has been remembered through the act of praying. The difficult relationship with her mother and the limited family support suggests that Bella needs to feel care and love which she seeks through prayer. Her use of the word 'just' emphasises her perception of the simplicity of her request. Bella describes

praying with her sister and with members of the mental health support group. Praying together with people of the same religion is a social activity which brings Bella closer to human interaction and as a consequence, has a positive impact on her self-worth. In the same way, Martha appears to find comfort in the knowledge that her Church is praying for her. The importance of Martha's prayers are described in the following quotation.

> "So I just feel open to speak [ ] and I just believe that someone is hearing me [ ] on the other end. Because sometimes I pray for things [ ] and it do happen. [ ] Yeah it do happen, not everything I prayed for you know happen. But most things I prayed for you know always get result so I know that there is you know."
>
> *(Martha, page 12/ lines 252-261)*

For Martha, religion signifies personal support through difficult times. Praying to God is important to Martha in terms of asking for help and providing her with a support system to confide in. Her prayers are answered which reinforces her beliefs and as a consequence, Martha's ability to communicate with God in times of distress helps her to manage her mental illness.

Spirituality appears to function as a means to access a community for support. A sense of connection to others is identifiable in Claire's account as a focus of importance. For Claire, the connection is found in the context of the media in the form of watching Christian television channels. Claire says:

> "There's also [ ] nowadays like Christian channels [ ] and so there are certain preachers which I - which I like quite a lot [ ] and other preachers which I, don't like so much. [ ] But the ones I do like erm, their words can be very er, comforting [ ] And things like that [ ] even though it's just a TV programme [ ] can help you through. 'Cause sometimes they'll talk about someone, someone's situation that er they know, [ ] and it can be something similar to you. [ ] And it can erm, make you feel

> that you're not alone. [ ] That someone else is in that situation and they've come through the situation."
>
> *(Claire, pages 24-25/ lines 583-602)*

Although the support is anonymous and lacking in direct human contact, Claire is able to relate to the stories of other individuals which highlights that she is 'not alone'. She therefore finds comfort and reassurance which reduces her feeling of isolation. Claire adapts her religion to meet her spiritual needs by selecting the elements which she perceives to be helpful, which is evident in her reference to liking 'certain preachers'. Like other participants, Claire lives in the shadow of difficult family relationships and a limited support network. Despite this fact, Claire is able to find a source of guidance and support within the media.

The meaning of spirituality is broader than religion for some participants as it appears to encompass wider concepts in the context of a framework for living. For Farida, a defining feature of her spirituality is her values and feelings. Farida explains:

> "To me it means how I feel on the inside [ ] how, erm about, like my morals, [ ] erm the kind of things I, er the reasons I live, [ ] the reasons that I er do what I do [ ] on a day to day basis. And erm the things erm, the things that are important to me.
>
> *(Farida, pages 1-2/ lines 18-26)*

Spirituality for Farida appears to be intensely personal which is central to her account. Unlike other participants who immediately talk about their religion, Farida's description does not refer to her following of Islam. Her inner feelings and beliefs are at the forefront of her discussion and appear to overshadow her religion. Farida's morals appear to provide a structure for her life and a sense

of stability. Her daily life appears to be a focus of concern which perhaps is an indication of her current priorities. Religion however, remains an important part of Farida's spirituality. She explains:

> "It's always been there. It's always been like, something to work towards. Be like dad."
>
> *(Farida, page 29/ lines 535-536)*

Farida's religion, Islam, appears to have been part of her upbringing. Farida's goal of 'something to work towards' suggests her admiration for her father's commitment to religion and indicates that her spirituality is heavily linked to her relationship with her father. Reflecting on this, I identified a similar relationship with my father which helped me to understand Farida's experience with her spirituality. Farida's father suffers from mental health problems therefore Farida shares the understanding with her father of being mentally unwell and the significance of their religion in the context of ill health.

The meaning of spirituality may be associated with creativity. It appears that writing poetry is influenced by religion and functions as a form of self-expression to cope with mental illness. Creativity is a significant feature for Bella which is suggested by the close link between her poetry and her religion in the following extract.

> "I used to write poems and I felt like that came from God. Like, I felt like the thoughts that I got from my head [ ] God gave me those thoughts [ ] to write down. [ ] Like how I believe about God and how I believe about what's happening to myself. [ ] That came from God to me."
>
> *(Bella, pages 5-6/ lines 86-95)*

Writing poetry appears to help Bella to feel closer to God through a direct and personal form of communication. Bella indicates that she is searching for answers to make sense of her mental illness. Poetry seems to provide Bella with a mechanism to discover those answers which is suggested in her belief that her poetic thoughts come from God 'about what's happening to myself'. A similar experience of creativity is shared by Claire within her spirituality. Claire writes poems and songs which she describes in the following extract.

> "And that's where spirituality comes into it [ ] 'cause I do a lot of erm, er poetry and song writing. [ ] And when I do that, erm, its always amazing to erm sort of have a blank-blank piece of paper [ ] and then in like sort of half an hour of something you've got a song. You've created something [ ] that didn't exist from out of nowhere. [ ] And that's an amazing part. That is probably like, erm, one of the strongest areas where I feel that spirituality comes through. [ ] Because even when I'm writing a song I might have, I might need just one specific word [ ] and suddenly that word comes from nowhere [ ] and you think oh where did that word come from? That's so perfect."
>
> *(Claire, page 4/ lines 75-96)*

Claire's ability to be creative indicates this is a vital feature of her spirituality. In Claire's description, her experience differs from that of Bella's as the words come from 'nowhere' rather than directly from God, but still maintain a spiritual connection. The words 'you've created something [ ] that didn't exist' suggest the sense of satisfaction and independence that Claire gains from her spirituality. The emphasis on 'amazing' demonstrates Claire's enthusiasm and the positivity she gains from her writing. Claire was once in employment but now no longer works as a result of her mental illness, all of which will have an impact on her sense of achievement. Creativity has a positive influence on Claire's self-esteem which is significant in the context of living with mental illness and the inability to work.

In addition to her religion and creativity, the natural world appears to be of central importance to Claire's spirituality. Claire describes the inspiration she gains from being amongst nature.

> "I live opposite a park, [ ] and I go er running [ ] erm, like a couple of times a week, erm, and sometimes when I'm-when I'm running, it's- it's good because like you erm, y- you're in nature [ ] which is again that's where the spirituality starts. Because I- I run in the park erm, all year round. [ ] I see the seasons change and so, [ ] the one, the one thing that's really touched me spiritually [ ] is after winter, [ ] when the first buds come out [ ] on the - on the very tiny tip of green comes out on the trees [ ] and you think, spring's nearly here [ ] and that's a huge help for me 'cause I do struggle through the winter time [ ] with my moods and that. [ ] So, so that's- that's erm, so that-that is just change, watching the change in the seasons probably this is why I say spirituality is not just for me it's Church, [ ] it's in everyday. So seeing the seasons change [ ] seeing the flowers grow up from nowhere."
>
> *(Claire, pages26-27/ lines 640-671)*

Claire seeks solace in nature which is suggested in her reference to the help she feels from the visible signs of Spring. Claire describes feeling 'touched' which highlights the close spiritual connection she feels to the seasonal changes. She refers specifically to the image of flowers and buds which suggests new life, a fresh beginning and a sense of hope for the future. On reflection, personal experience of a family member who experiences low mood and finds comfort in the Spring season helped me to appreciate Claire's perspective. Claire equates the park to 'a religious place' in the following extract.

> "I live opposite it, [ ] it's-it's quite almost like a sort of a religious place for me in that [ ] I go there regularly and-and it's amazing that just like thoughts come from nowhere."
>
> *(Claire, page 30/ lines 728-732)*

The park and nature appear to meet Claire's unmet need of an environment in which she can relax and think clearly. She has faced harm by people in the past and perhaps feels safe within the non-threatening natural environment. Claire's spirituality involves an intimate connection between her religion, her connection to nature and her ability to be creative. Each aspect of her spirituality provides Claire with the support and encouragement that she seeks which helps her to cope with her mental illness.

In summary this theme illustrates the broad meaning of spirituality for the participants. Spirituality can be understood in the context of religion, personal values, creativity and nature. For some participants, religious beliefs have been triggered by the experience of facing serious illness. The meaning of spirituality can be seen as the provision of support through prayer and a sense of connection to others. The following theme examines the negative effects of spirituality.

5.4.2 Emergent theme: I'm not handling it well: Negative effects of spirituality

This theme addresses the difficulties associated with spirituality which are experienced by some participants during times of mental illness. Mental health problems affect thought processes and concentration which appears to affect the overall relationship with religious beliefs. Although spirituality is

deeply important to all the participants, three people describe a range of negative aspects to their spirituality in which they struggle to cope with their beliefs. Thomas explains how he attempts to control his relationship with his spirituality.

> "Just that when I'm well, [ ] I'm more lost in a physical world and don't have much time for my spiritual world. So, I try and have a Bible study once a fortnight to connect me with, keep me in touch with my spiritual world. Cause even though it plays a strong part in my life, I don't engage with it in my everyday to day life when I'm well. [ ] It's usually when I'm unwell that I do that. [ ] So I try to relate to it fortnightly. And if it gets more, so heavy, that it becomes, it's getting involved with my life more than the fortnightly relation [ ] I try to stray from it [ ] to keep it fortnightly so that I can cope cause, I find it all overwhelming. I find the spiritual part of my life very overwhelming."
>
> *(Thomas, pages25-26/ lines 458-472)*

A major area of concern for Thomas is his ability to control his contact with his spirituality. His need for control is highlighted in his acknowledgement of both the positive and negative aspects of his spirituality. Spirituality continues to function as a source of support when he is mentally ill however, for Thomas the 'overwhelming' feature of his spirituality is a recurring feeling when he is well. The volume of information to comprehend from his religion becomes a source of anxiety for Thomas. The use of 'heavy' implies the physical burden of his religion from which he chooses to distance himself during periods of feeling well. As a result, it is important for Thomas to manage the frequency of when he connects with his spirituality by turning to his religion primarily when he is feeling mentally unwell.

In contrast, Martha controls her relationship with spirituality by distancing herself from her religion during periods of mental illness. Martha describes the

negative aspects of her religion which have an impact upon her mental health. She explains:

> "But I believe my religious belief, it was, when I'm ill, it's sort of a barrier. [ ] Yeah, towards like the, the health. [ ] Because with my religious belief I always believe well, if when I'm sick I'm going to pray [ ] and I'm going to read my Bible. [ ] Because I just believe. But when I'm reading the Bible at the time when I'm ill, [ ] I can't understand the Bible. And sometimes it affects my head more. [ ] But just because I have got beliefs, say well, God will heal me, or God will do that. [ ] I keep praying and, you know, and maybe I've been stubborn when the Doctor telling me take my tablet and because I said I'm praying to God and I know God is going to. So why I said it's a barrier is because of sometimes I'm a bit stubborn. [ ] And I will say, God will do that, when the Doctors want to give me medication. You know so it's not until, they force me to the medication somehow [ ] And then when I'm coming around now, well I I sort of in lining with them. [ ] You know. And I understand what they were doing. They were doing it for my good. [ ] Because although I believe in God at that time, [ ] my Christianity couldn't help me because I was out of my mind. [ ] And I'm trying to read the Bible but it was con-confusing me and I'm trying to pray but I you know, so, [ ] the one that was to help me would be the Doctors at that moment."
>
> *(Martha, pages 19-21/ lines 435-469)*

A concern for Martha is her repeated reference in her account to the sense of confusion caused by her religion when she is mentally unwell. Reading the Bible and praying are defining features of Martha's spirituality however Martha appears unable to focus and 'understand' the Bible when she is ill. What is normally a source of support for Martha, becomes a 'barrier' towards her wellbeing and as a consequence, Martha's relationship with her spirituality changes during periods of ill health. What is significant for Martha is her recognition that she predominantly requires professional help for her mental health, whilst her religion plays a temporarily smaller role in her life. Martha's account emphasises her belief that God should help her and God is a source of help in times of need. Alongside her beliefs however, Martha accepts the reality

of accepting treatment from her Doctor when she is feeling unwell, rather than her reliance on God. Martha adapts her beliefs and practices to her needs as she explains in the following extract.

> "If I'm going into a depressive state, [ ] I might not read my Bible like that time, [ ] but I always pray. [ ] I felt I do a lot of praying more than reading. I read my Bible but I know I pray more."
>
> *(Martha, page 31/ lines 704-710)*

The excerpt demonstrates that Martha does not completely abandon her faith despite the negative effects on her concentration. Although she distances herself from the Bible, what remains important to Martha is her ability to pray when she is feeling mentally unwell. Martha places more emphasis upon praying during these times which demonstrates the complexity of her religious beliefs in that they remain important to Martha during illness, despite her difficulties with reading the Bible.

Farida also describes a complex relationship with her spirituality. Farida suggests experiencing a disconnection with her religion since becoming mentally unwell.

> "Spirituality's got a small place in my life at the moment because I'm not handling it well [ ] That's not what I'm aiming for [ ] I'm aiming to get back to, erm, it being more important [ ] but I'm still treating myself. I'm doing it slowly slowly [ ] I'm not putting pressure on myself, because otherwise I'm going to go backwards. [ ] So I'm going to get back in… slowly.
>
> *(Farida, page 23/ lines 419-430)*

Farida indicates that she has distanced herself from her religion and offers a powerful account of her struggle with her religious identity as a Muslim. Her words 'otherwise I'm going to go backwards' suggests the fragility of her

beliefs, which is of particular significance given that religion is an important feature of Farida's family, her upbringing and therefore is dominant for Farida in a cultural context. She has however, chosen to give it a 'small place' in her life to cope with the negative impact upon her mental health. Her words 'at the moment' imply a lack of permanence to the situation and suggests her hope for the possibility of change in which Farida intends to reconnect with her religion. In the following extract, Farida describes her struggle with her religion and the expectation that God should help her to get better.

> "Since I've been well, I find it very difficult to, *accept* things [ ] Like religiously you'd say 'Oh, you're going through a bad time' [ ] It's no. You're supposed to say, supposed to believe it's all from God and everything will get better. But erm, it's not as simple as that when you're not well. [ ] Because you do erm, you find it hard to do the simple things. One thing I really miss, I don't know why but, I find it really hard to actually pray. [ ] I find that I can't er communicate with God because I feel like, I probably feel,… lost. I feel lost. And I feel like, … I can't, say exactly what I want to say. [ ] There's that, I'm confused about what's right and wrong. [ ] Because erm, I shouldn't be. I shouldn't be, because it's erm, erm, it's ok to be confused. [ ] It's it's part of life, [ ] erm, yeah it's made it a lot harder. [ ] A bit like, you know some people say, especially any religious person will say 'Oh you know, sit down and pray and everything will be ok'. Now that only works when you're happy [LAUGHS]. When you're down, [ ] it doesn't work straight away because you have to be a lot more patient. And that's the time you don't have any patience. And erm, you kind of move away from it instead. So I know that I have. I've found that it's just, it's best to. I felt like it was easier to just ignore it."
>
> *(Farida, pages 6-8/ lines 107-136)*

Farida expresses her concern that religion 'doesn't work' when she feels unwell. Talking to God through prayer is significant for Farida however, as a result of mental illness prayer is no longer effective for Farida. Despite the limitations of praying, she feels pressured to continue to believe in help from God which has left her feeling 'lost' and 'confused' about her beliefs. Farida's

laughter demonstrates her discomfort with the topic, which reflects the significance of her decision to distance herself from her faith. By abandoning her religion, Farida becomes an outsider which adds to her feeling of alienation. In comparison to other participants who choose to turn to God in times of illness, Farida's relationship with God has been affected and as a consequence she appears to feel a sense of uncertainty and isolation.

In summary, this theme highlights how the meaning of spirituality is complex and specific to the individual. The relationship with spirituality can change during periods of mental stability and mental illness. What is seen within religion by some participants as a source of personal support and comfort, can also lead to feelings of confusion and anxiety. As a result, individuals take steps to carefully control their relationship with spirituality which has an impact upon their mental health. The next section explores the role of spirituality in coping with the experience of loss.

5.5 Super-ordinate Theme b. Experience of Loss

Spirituality appears to provide vital support where there is a feeling of loss in life. Four of the participants indicate that their spiritual beliefs fill a void and provide them with a support system for coping with difficulties. Given the context of living with mental illness, loss is expressed by all participants in relation to living with a loss of power, the experience of isolation, judgement from others and a lack of support. The participants talk about a range of ways

in which their lives are disempowered which is explored in the following emergent theme.

5.5.1 Emergent Theme: I'm in turmoil: Living with disempowerment

This theme examines the impact of disempowerment in relation to the meaning of spirituality. All of the participants talk about their experience of living with mental illness which suggests a source of disempowerment. Thomas describes the impact of mental illness upon his ability to control the course of his life in the following extract.

> "Before everything used to be jumbled up in my life [ ] and I just like, rather than navigating through life, life was navigating me."
>
> *(Thomas, page 4/ lines 69-71)*

Thomas' 'jumbled up' life suggests a disorganised and chaotic existence therefore, a sense of order is important to Thomas which he believes has been provided by his religion. His account suggests that previously his life lacked direction and focus which positions Thomas as vulnerable and powerless. As a result of mental illness, he was denied the ability to make personal decisions and take control as in his life, control is predominantly challenged by the experience of mental illness. Religion and spirituality function as enabling Thomas to regain control of his life. The issue of power is clearly important to Thomas as it is a recurring topic throughout his response. The loss of power during a hospital admission coupled with the struggle to cope with the symptoms of psychosis are expressed in the following quotation. Thomas visualises a scenario to express his spiritual needs in mental health care.

> "Being listened to and worked with [ ] rather than sedated and left to calm. [ ] Yeah, sometimes I don't think it's all, sometimes I don't think medication's the answer. [ ] Sometimes I think a two-way conversation with active, with active activity involved in a conversation. Like I want to go to a shop for some fresh air cause I'm cooked in this environment and I'm full of hallucination and voices. Now something like that, when you're under a section, they'll say 'no'. [ ] cause you'll run away or something like that. Or you'll fight. Now, to me, that's not helping my spirituality [ ] But to be escorted to a shop, even if it's in handcuffs [ ] would help my spirituality because it can break the cycle of hallucination.
>
> *(Thomas, pages 23-24/lines 419-433)*

Thomas draws attention to the fact that he needs to 'be listened to' rather than 'left' which suggests that he feels abandoned and isolated at a time when he is feeling most vulnerable. His desire to be 'worked with' rather than to passively receive care indicates a desire for greater respect and equality. Thomas emphasises his need for 'conversation' which highlights his perception of a lack of power and his inability to voice his unmet needs. In explaining the challenge of mental illness and the hospital environment, Thomas draws on the image of feeling 'cooked' to express the stifling restrictions placed upon his independence. Reflecting on this, personal experience of working as a Mental Health nurse enabled me to understand Thomas' account. His desperation for some level of independence is emphasised by the use of 'even' when he describes going to a shop in handcuffs. Thomas will settle for the visible loss of power imposed by handcuffs to exercise some control over his symptoms in order to lessen his disempowerment and meet his spiritual needs.

Farida shares the experience of disempowerment in relation to her need for her voice to be heard. She describes in the following extract her desperation for mental health support during her pregnancy.

> "Telling your midwife you feel like that, they're like, the the the response you get is 'oh it's a new, er, a new change for you. You're going through a lot of changes. It's your hormones, that's why you're upset. It's ok.' They don't even listen. You tell them. I was erm anxious, feeling very low throughout my whole pregnancy. I must have cried through most of it. And I used to be worried thinking 'Oh my God, my baby must be able to know that mummy's so unhappy the whole time.' No one did anything. Went through the whole thing with everyone just saying 'it's alright, you're worried because you know, you're putting on weight or you're just worried because you know, a lot of responsibility, that's it. And that's all it is. That's all the reaction you get. And that's the hardest thing I think you have to, you have to literally have a breakdown and I dunno, cause a scene for someone to help you."
>
> *(Farida, pages 65-66/ lines 1259-1270)*

Farida articulates her frustration in her attempt to seek help for her mental health. She has unmet needs and doesn't believe that she has access to support which is the result of other people's attitudes towards her illness. The lack of understanding from others leaves Farida with no other option but to lose personal control by having a 'breakdown' and consequently 'cause a scene' to draw attention to her needs. The description suggests the loss of power that Farida feels in her life as a result of her condition and other people's behaviour towards her mental illness. Farida differs from the other participants in her decision to move away from her religious beliefs in order to cope with her feeling of disempowerment.

Bella's description of the impact of mental illness highlights her disempowerment as a consequence of living with the uncertainty of relapse.

Her repeated reference to feeling ‘scared’ emphasises the intense distress caused by living with mental illness.

> “Mental health is not nice. If you wanna call it mental health. Yeah, it does set you back. ‘Cause you’re scared of having a relapse. You’re scared of the voices coming back. You’re scared of walking the streets barefooted. You’re scared of wanting to try to kill yourself. ‘Cause you can’t take no more ‘cause the pressures getting too much. And then you’re scared of, if you go out into the real world, if there’s too much stress, how that’s going to impact your mental health.”
>
> *(Bella, page 51/ lines 936-939)*

Bella discusses her illness in terms of distress and fear which contributes towards her feeling of disempowerment. The rich and detailed description suggests that this account is central to understanding Bella’s experience of living with mental illness. What can be learnt from this extract is the difficulty Bella feels in discussing her experience of illness. Bella’s use of the second person with the words ‘your mental health’ creates a distance between herself and the topic which suggests her fear in facing her personal circumstances. Bella draws on the image of ‘walking the streets barefooted’ which reflects a total loss of control and extreme vulnerability as a result of her mental illness. The severity of illness is highlighted in the threat to taking her own life which points to her feeling of a loss of future. Bella disagrees with the idea of the term mental ‘health’ which she feels grossly misrepresents her experience of living in constant fear and her helpless outlook on life. Consequently, Bella questions her place in the ‘real world’ which she associates with stress and the risk of becoming unwell. As a result of the disempowerment brought about by her mental illness, Bella turns to her religion as a source of support.

Loss and disempowerment are expressed by Bella in the context of her role and identity. Bella describes the loss of an independent life which she attributes to her mental illness.

> "I haven't progressed forward in my life as quick or as well as I feel that I should have. I feel like, because I've heard voices it's set me back. [ ] And erm, I haven't gone forward as quick as I want to. [ ] When I was feeling fine [ ] I was well enough to do what I want and pleased myself and carry on. [ ] But then, it's made me step back and think about my faith a bit more. [ ] My spiritual walk a bit more. [ ] What does God require of me? And and take things a bit more at a slower pace. [ ] Where I was going at a fast pace before. [ ] And more or less, not doing what I want but just going about my business and not thinking about anything else. [ ] [COUGHS] So, I believe that I should have had a career by now [ ] I should have been working. [ ] But I'm not. But I'm volunteering."
>
> *(Bella, pages 49-50/ lines 897-920)*

An independent future which leads to personal empowerment is an important consideration for Bella. Mental illness has had a negative impact upon Bella's sense of identity, specifically because she appears to see herself as a person who has been denied the opportunity to work and live independently. The words 'should have had a career' suggests her sense of disappointment and highlights to Bella her loss of future and purpose. Bella's role is now defined by 'volunteering' rather than the position of empowerment associated with a professional career. Although Bella's account appears to reflect her dissatisfaction with her position in life, her role as a volunteer demonstrates her ability to adapt and therefore regain some level of personal control. In addition, Bella suggests that a benefit of her circumstances is the time she has gained to reflect on her 'spiritual walk' and her faith.

For Claire, a loss of inner peace is significant in relation to her experience of mental illness and disempowerment. Claire explains:

> "If I'm having a difficult time [ ] and I'm in turmoil, [ ] and like I can't-I can't focus or erm, my thoughts are erratic. [ ] Then a spiritual sign would be that erm, I'd find -that I'd find a sense of peace within myself. [ ] And when I get back to that point of being peaceful within myself, [ ] then I'd know whatever the circumstances, everything will be alright."
>
> *(Claire, pages 31-32/ lines 764-775)*

Claire's description of her illness reflects intense distress with her reference to being 'in turmoil'. She is disempowered by her inability to think clearly which presents a barrier to the religious support she gains from reading and praying. Despite the disruption to her thoughts, Claire visualises a situation in which her spirituality functions as a source of comfort whereby she is able to regain personal control of her thoughts and feelings. A sense of peace is important to Claire which is highlighted by the reassurance and sense of hope that spirituality brings to overcome her disempowerment.

Overall, this theme appears to suggest that loss is experienced in the context of disempowerment. The impact of mental illness may lead to a loss of control over life, for example in the experience of a hospital admission. Some participants express that they feel ignored by others through disempowerment and consequently turn to spirituality and religion to address unmet needs. The next emergent theme examines the experience of loss in relation to living with isolation and judgement.

5.5.2 Emergent Theme: No one can understand you: Living with isolation and judgement

This theme addresses isolation and judgement which are intimately linked. Farida expresses a complex experience of isolation which is two-fold. Firstly, she appears to be isolated from her friends and family as a consequence of their judgement about her mental illness. Secondly Farida suggests that she faces isolation from social groups because of judgement made about her religion and ethnicity. In order to cope with the stigma of mental illness, Farida chooses to hide her illness by 'masking everything'.

> "I'm fantastic at masking everything. [LAUGHS] I erm, I perfected it. I, it took me a long time to act erm, how I'm actually feeling in front of other people. Erm, my initial reaction was always just to say I'm fine, I'm ok [ ] And erm, the hardest thing was, that no matter how down I felt whenever I was in front of another person, a smile would come on my face and it wouldn't go. My face would ache later and I'm thinking why am I smiling? I could have been, erm, crying only half an hour before, crying about someone in front of me and that's it. It's like, erm. You have, well *I* have, always made sure to remain composed in front of other people. And when you're not feeling well, the only thing I could do was hide.
>
> *(Farida, page 14/ lines 250-259)*

In the absence of a support system, Farida protects herself by hiding her feelings and signs of mental illness. The word 'perfected' implies that her strategy has been practiced over time which suggests that her isolation has been an ongoing experience. Her laughter indicates her unease with discussing the matter and implies her struggle to balance her public and private identities. Farida's public identity is to hide her illness behind a 'smile' to create the illusion that she is feeling positive and in control. In private, Farida feels 'down' which is hidden away from public view. Her reference to her face aching

demonstrates the enormity of effort involved to hide her emotions. She is not used to communicating her feelings which leaves her feeling lonely and isolated in her experience. To understand Farida's reluctance to disclose her feelings, it is important to engage with the cultural context. Farida explains the stigma surrounding mental illness within the Asian community.

> "I see people, particularly being on Asian people, they erm, they're unwell. And Mum would say 'Oh she's a bit mad'. Or she's a bit and daren't go for help, go to a doctor because such and such person would be mad at her, her mother or mother in law or whatever will say 'No people will talk'. You can't go and get help. [ ] See, me personally, my mother in law doesn't even know. That was very difficult for me. I haven't even told my mother in law. [ ] Because she would, she would never understand. She'd be absolutely ashamed [ ] and erm, that would make things [LAUGHS] much worse. So erm, my husband finds it difficult. He has to keep it all to himself [LAUGHS] [ ] And he says it's so hard, to lie when you're at the counsellor or to lie and I have to make up all these things about where you are. [ ] And, but I don't want to hear it. [ ] I know because I've heard them say it about other people. Such and such person's mad, don't go near her. Such and such person, you know, can give you bad luck."
>
> *(Farida, pages 59-60/ lines 1117-1138)*

There are several significant issues within this extract. Her mother's comments about 'mad' people suggests an impact on Farida's sense of self as a person who is unworthy of support. The negative thinking about mental illness confirms for Farida the discriminatory attitudes that she fears from other close relatives, in the context of bringing shame and 'bad luck'. As a consequence, trust and communication are eroded which leads to hiding her illness and difficult family relationships. Other than the support from her husband, Farida is alone in her mental illness because of the judgement she fears that she will face. Her inability to confide in her mother in law suggests a

sense of isolation and helplessness. In contrast despite the immense effort taken to hide her illness Farida struggles to maintain her secret as she explains:

> "I find I can't share it [ ] and erm I find that now, that I will, that I, I'm dying to tell other people [LAUGHS] but I haven't got the confidence to [ ] erm to say it and not feel absolutely frightened about saying it."
>
> *(Farida, pages 55-56/ lines 1051-1056)*

Farida's expression of 'dying to tell' underlines her desperation to be accepted for who she is as a person living with mental illness. She however remains trapped in isolation and fear because of her perceived threat of judgement.

Farida appears uncomfortable to discuss her religion openly. In her private identity, her religion is personal which is perhaps to avoid the prejudice she fears from others within social groups. In relation to mental health services, Farida's view is strongly against having her spiritual needs addressed which she expresses in the following extract.

> "I don't think it should be brought up. You know I think I would have hated it [ ] you know attention to it or [ ] you know, pointed out that I was Muslim. Or anything like that, I don't want that pointed out [ ] makes no difference, should make *no* difference to anyone else in the room [ ] And er, it wouldn't, shouldn't affect the way I treat anyone as well. [ ] No I don't think it should be, should be brought up."
>
> *(Farida, page 50/ lines 938-950)*

Despite the fact that Farida dresses as a Muslim woman and therefore openly follows Islam, she repeatedly objects to discussion about her beliefs and appears to be extremely uncomfortable with talking about her religion. A striking feature of her account is the emphasis of her concerns about the

reaction she would face from other people, with her words ‘should make no difference’ to anyone. In the following extract she describes her fear of prejudice towards Muslims in the current climate with her reference to the difficulties of being different ‘at the moment’.

> “No [ ] I hate being put into little groups [ ] Makes you feel erm… [SIGHS] like an alien (LAUGHS) [ ] I don’t want that [ ] Erm… [SIGHS] yeah it’s bad, it’s hard enough when you go somewhere new, or whether if you’re the only person from a different colour and anything at the moment [ ] and you don’t want people looking and you [ ] or erm [ ] I guess er no, it makes you nervous anyway [ ] and then to top it off, when you’re not feeling well, it’s worse.”
>
> *(Farida, pages 44-45/ lines 833-849)*

Farida sees both her religion and her ethnicity as socially divisive. She perceives talking about her religious needs as a reminder of the prejudice she feels from others which adds to her sense of vulnerability. Farida wants to feel included rather than excluded as the outcome of being segregated into a ‘group’. She draws on the image of an alien to express her sense of isolation and the judgement she feels from others which demonstrates the deep impact of social attitudes in the context of current political events. Socially, Farida feels threatened and uncomfortable with the attention by her description of feeling ‘nervous’ of people looking at her. Her fear of prejudice extends to a range of settings, including attending playgroups with her daughter. Farida says:

> “I find that sometimes even when I’m, going to playgroups and things like that, with my daughter and I get asked erm, you know, silly questions about what’s on my head and I think ‘Do you *have* to? Now I’m uncomfortable. Did you, did you *need* to bring it up?’ And it just, it it puts you in a separate corner from everyone else. I I don’t want to be in a separate corner.”
>
> *(Farida, page 47/ lines 883-887)*

Farida experiences a conflict with her spirituality in that her religious beliefs frequently present a barrier to being accepted in a range of social situations, which is suggested by her use of the word ‘even’ in her reference to the playgroups. Farida struggles with having to explain her identity and perceives what may be intended as an innocent question about her headscarf as a personal attack. She describes her feeling of isolation as being placed ‘in a separate corner’ which suggests her loneliness in a range of environments. Although she shares the experience of being a mother, Farida is not part of the group and remains detached as an outsider. These factors, coupled with having a mental health problem, have a negative effect on Farida’s confidence and self-esteem which enhance her isolation.

Farida’s experience of isolation affects her ability to understand her mental illness. She explains:

> “I thought I wasn’t handling things like a normal person would. That’s what I kept telling myself. [ ] It took me quite a while to realise that I wasn’t well. [ ] Erm, I just felt lost at the time. I thought, it’s like er, you feel like you’re isolating yourself from everyone because no one can understand you [ ] and they definitely can't when you don’t understand yourself. Then I just I did feel lost. I felt all alone. Because I couldn't understand myself and no one else could understand me.”
>
> *(Farida, page 13/ lines 221-231)*

She articulates her struggle to understand her illness whereby she feels ‘lost’ and ‘alone’, which suggests her isolation and her vulnerability. Farida’s self-dialogue ‘I kept telling myself’ appears to be her coping strategy of internalising her experience and continues the suggestion that she has no-one to confide in. Farida’s loneliness appears to express a strong need to be

understood and accepted by others. She reflects a sense of detachment in her description 'I couldn't understand myself' which has an impact on her sense of identity. Her belief that she is not understood echoes her feeling of disempowerment during her pregnancy whereby her voice was not heard. The extract captures her disconnection from others and her feeling of no longer belonging.

Farida's isolation from hiding her illness continues in her role as a parent in which she felt alone in the new and unknown experience of motherhood. Farida struggled to bond with her daughter which became particularly difficult when her close friend experienced the death of her child. Farida and her friend had become mothers at a similar time and had therefore shared the experience of becoming parents. The combination of the close friendship, the loss of the child and the experience of mental illness leaves Farida feeling guilty about her inability to relate to her own child. As Farida explains:

> "I felt guilty because I was, erm, struggling [ ] to accept mine and she'd lost hers, and erm, [ ] just having to be strong in front of her. Trying really hard not to tell her how much I erm, erm was struggling with mine [ ] I was trying to keep it to myself."
> *(Farida, pages 26-27/ lines 490-495)*

Her words 'keep it to myself' highlight Farida's feeling of isolation in her experience of illness which again points to her absence of a support network to confide in. Farida makes reference to support from God in helping her to love her child however, her isolation is centred around her inability to disclose her true feelings to her friend. She describes the need to be 'strong in front of her' which appears to suggest that Farida has to keep her sorrow within. Farida

therefore continues to live with isolation despite the support from her spiritual beliefs.

Bella shares the experience of living with isolation in relation to her need to be understood. Bella explains:

> "I think when you follow Christ, you've got an example to follow by. In this world there's nobody to follow. [ ] 'Cause if you've been abused and people are mistreating you, you've got nobody to turn to. [ ] You've got no role model or nobody who understands."
>
> *(Bella, page 13/ lines 236-240)*

Bella speaks about her childhood experience of abuse and about her disappointment to find a role model with which to identify. In this context Bella's vulnerability from her childhood has left her feeling abandoned with 'nobody to turn to'. Bella is positioned as a person who has a void in her life by her unmet need of someone 'to follow' to fulfil a need for guidance and belonging. The absence of a role model in her life has left Bella feeling lost in her experience and misunderstood. Her isolation and loneliness have an impact on her sense of identity which she addresses by turning to her beliefs in Christ. Religion meets Bella's need to be understood which helps her to make sense of her experience.

In contrast, Bella describes her experience of facing isolation and judgement in the context of facing negative attitudes from a Church concerning her appearance.

> "In Rastafarian belief they have dreadlocks. I've chosen to have dreadlocks now because I believe that my hair is Afro Caribbean hair, and it's easier for me to manage this way. [ ]

> So I've chose, not because I wanna be a Rastafarian, but because I'm a Christian at heart. And that's what's the most important thing, is your heart, where your heart is. I've chose to have it because it's a hairstyle. [ ] And I just want, it's easier to manage. And I when I went to a Christian Church they told me that I couldn't have it, and I cut it off. [ ] Yeah, and that sort of confused my spiritual walk with God [ ] Yeah, because I felt like well, why are these people judging me? And I was trying to please them, and not please God. [ ] To me, I was pleasing people. [ ] And I went there with a wig on, and they said 'that looks better'. And I thought, I've got my natural hair and you're telling me that the wig looks better [ ] than my natural hair. And they didn't know that my natural hair, if it was extensions or if it was my natural hair [ ] And when they found out it was dreadlocks they said not because it's it's involved in other religions. But I'm not choosing to be a part of that religion. I'm choosing to be a Christian."
>
> *(Bella, pages 44-45/ lines 804-825)*

The judgement from the Church about the appearance of her hair appears to isolate Bella to a greater degree. Conditions are placed by the Church which determine her acceptance. The experience leads Bella to question her religion which is evident in the words 'confused my spiritual walk with God'. Despite her confusion, what remains important to Bella is her priority to meet the demands of God to maintain the personal relationship which addresses her isolation. Her isolation is also apparent in her experience of searching for a Church during a time of crisis.

> "I never had a settled Church where I went to, I didn't feel safe or, a belon, a sense of belonging. But I've always read my Bible. And when I was younger I went to Sunday School for like seven years, and that Church is in [name of city], being in [ ], when I moved to [name of city], in 2000, I was looking for a Church, when I was start - when I was starting to have my breakdown."
>
> *(Bella, page 30/ lines 543-546)*

The impact on belonging is clearly significant for Bella. The interview questions made no prior reference to a sense of belonging. Bella takes the

lead to raise the issue in her response, which is significant with difficult family relationships and a lack of support networks. Bella describes her search for a community to which she can belong to gain a sense of identity. She attempts to seek refuge in a Church but she continues to feel alienated. Bella sees her religion as a great source of support however, the Church reinforces her isolation as she doesn't feel 'a sense of belonging'. What is important to Bella is her personal relationship with God and the Bible which permeates her experience of spirituality.

Claire describes a similar experience of isolation in her search for a Church.

> "I go to a few different churches [ ] but I haven't really found the church where I felt that I was erm, at home in."
> *(Claire, page 11/ lines 268-270)*

The extract highlights Claire's desire to search for a place of security where she feels comfortable and a sense of belonging. Her reference to the idea of feeling 'at home' suggests that Claire is looking for a place which is familiar, comfortable and safe. The image suggests Claire's unmet need in the context of her difficult family relationships. Claire continues to look for a Church which does not lessen the exclusion that she feels. Although Claire sees herself as part of her religion, she also feels detached as an outsider. In contrast, Claire has previously referred to her local park as 'a religious place' which appears to meet Claire's unmet needs of living with isolation. Claire runs regularly in the park and benefits from being close to nature therefore where Claire feels isolated by the Church, she finds a sense of belonging within nature.

A sense of isolation and judgement appears to be experienced within hospital within the context of spiritual beliefs. Bella explains:

> "When I first went to hospital and I first carried my Bible [ ] the woman asked, the nurse, she asked me 'What have I got that for?' [ ] I said 'it's cause I'm praying'. What I was going through was a traumatic time and I needed something to rely on. [ ] I couldn't rely on them 'cause all they're gonna say is just watch me. That's all they were doing was just watching me."
>
> *(Bella, page 29/ lines 527-535)*

Bella's account reflects the judgement she feels from the nurse because she is carrying her Bible. Bella turns to reading the Bible and praying as a source of support however, a major concern for Bella is the lack of understanding from staff about her religious needs which adds to her feeling of isolation. The account illustrates the power dynamics with the staff whom Bella refers to as 'they'. The relationship with the hospital staff fails to address Bella as a person with complex mental health needs and spiritual needs. This is particularly marked by the words 'all they were doing was just watching me' when Bella states that she is going through a 'traumatic time' and is need of stability.

Difficult family relationships are discussed as a source of isolation and judgement. For some participants, spiritual beliefs are the cause of family disputes. Bella describes her family's response towards her spirituality:

> "They think that I'm being brainwashed into the English. They say into the English system and it's not true. And that Haile Selasie is God."
>
> *(Bella, page 45/ lines 830-831)*

Bella is isolated from her family because of the difference in religious beliefs. The term ‘brainwashed’ suggests their judgement and disapproval and as a consequence, Bella is left with a limited support system to cope with her mental illness. Despite the family divisions which have arisen, Bella is committed to her religion from which she finds support. Similarly, Claire describes a lack of understanding from her family in the following extract.

> “I wouldn't have those sort of conversations [ ] with anyone in my family [ ] they’re not really er, sort of understanding [ ] I think - I think people in my - in my family have got their own beliefs.”
>
> *(Claire, pages 21-22/ lines 524-532)*

Privacy concerning her spirituality is important to Claire, particularly in the context of her family whereby she feels judged and therefore chooses not to confide in them about religious matters.

Claire is comfortable to discuss her spirituality with people who share similar beliefs and who are non-judgemental. She contacts a prayer telephone line and describes the benefits.

> “When I’ve wanted some specific guidance I have phoned a few times, to the prayer line, [ ] and that was helpful. [ ] Because, erm, it was good to speak to someone else [ ] who was a believer. [ ] And they, what they do is they they, they don’t give you advice, [ ] but they pray along with you. [ ] And that that sort of erm, is a good help. [ ] When you’re in like in difficult situations, [ ] you think oh what am I gonna do?”
>
> *(Claire, pages 10-11/ lines 247-264)*

The prayer line functions as a support system which enables Claire to feel included and accepted for who she is which results in a sense of belonging. The support to make decisions is important to Claire which is made clear from

the fact that she is not looking for a solution to her problems, but simply a means to ease her isolation and to cope with her mental illness. The help is found in the company of praying alongside 'a believer'. It appears that what is beneficial to Claire is that she retains her sense of control and independence to make her own decisions, whilst in the receipt of unconditional support.

In addition, Claire describes her experience of judgement and isolation from other aspects of her life which have shaped her spiritual beliefs. Her personal experience as a victim of bullying and racism has resulted in Claire's focus upon the importance of accepting other people.

> "I think at the end of the day, I have to look at how Jesus would look at that person as being a child of God and wouldn't [ ] judge them 'cause I think that's one of the things that is something that erm, I-I can't prescribe to, is judging people [ ] 'cause I think that's [ ] everyone's at a different stage in their life and at a different stage in their spiritual life. Even if they're not, even if they're maybe not even a belief-believe in God. They're still connected to like a higher [ ] higher power and everyone's at a different stage so I think it's best to be open minded and accept that people believe in different ways. [ ] But that whatever speaks to your heart is true for you."
>
> *(Claire, page 3/ lines 59-73)*

Claire's experience as a victim of prejudice appears to influence her attitudes towards other people. She is strongly against the idea of 'judging people' which is perhaps based upon her personal experience of suffering. Her attitude is to be open-minded and to view everyone equally. The scars from her experience of trauma have shaped her attitude towards others which she identifies in her religion.

> "I take my erm my lead from er my erm my Christianity from looking at the life of Jesus [ ] and thinking of how he will treat people [ ] and I think he would treat everybody, every person with love and respect."

(Claire, pages 2-3/ lines 49-54)

These values are important to Claire because she has the experience of what it feels like to be mistreated. She values the importance of equality in the use of her words 'treat everybody'. Similarly, Bella adds to this way of thinking.

> "I don't judge nobody. I accept people for who they are. Whatever beliefs they choose to have that's up to them."
> *(Bella, page 40/ lines 738-739)*

A non-judgemental attitude concerning other people's beliefs is clearly important to Bella. She is accepting of others which perhaps stems from her experience of changing her religion and the consequences she has faced from her family.

Martha discusses her experience of living with isolation and judgement in the context of dealing with rejection.

> "Because you know in life sometimes you get rejection. [ ] People will reject you, you know. Maybe, they might think they are, maybe up there more than you. [ ] Or they will do, but I comfort myself and I say, well God love me and God don't reject me. [ ] So you know I have that inner peace."
> *(Martha, page 29/ lines 658-665)*

The experience of rejection is significant to Martha as it shapes her belief that she is supported and comforted by God. Martha indicates her idea that God is more reliable than people as a source of support which gives her personal stability in the form of 'inner peace'. For Martha, religion provides her with 'love' to overcome her feelings of isolation and therefore positions her as a survivor.

In summary this theme suggests that loss is experienced in the sense of isolation from others and the impact of judgement which is linked to mental illness. What can be drawn from the extracts is the experience of living with isolation and the role of spirituality is complex and unique for each participant. In order to cope, some participants are in search of support from religious communities but continue to feel isolated. In other circumstances, religion can be perceived to be a barrier to social inclusion. The experience of trauma during childhood can lead to the search for positive figures within religion to provide guidance and hope for the future. For others, a belief in God can help some individuals to overcome the feeling of isolation. The next theme examines the role of spirituality in contributing towards feeling complete as a person.

5.6 Super-ordinate Theme c. Feel like a whole person

Spirituality appears to provide an opportunity for a sense of fulfilment, predominantly in situations where loss has occurred. For all the participants, a sense of wholeness is reflected in the expression of feeling secure, in control and a sense of purpose in life. All of the participants explain that spirituality gives them a sense of security and protection which is explored in the following emergent theme.

5.6.1 Emergent theme: It's God's Protection: A sense of security

A relationship with religion appears to provide a feeling of protection. In the context of living with the vulnerability associated with mental health problems, feeling protected is a source of support and reassurance. All of the

participants' views of spirituality as a means of security are captured in the way that they talk of feeling protected from harm. Martha referred to protection in relation to her experience of serious physical illness whereby she believes her life was saved by God. She also describes feeling protected in other ways.

> "And sometimes I can be, like, in a room, I can't say well but but I just put it down to say well it's God's protection. [ ] Sometime I can list I was going to do that. And the present of mind say don't do that, or, and when I don't do it it works out better on my behalf. [ ] If I did do it, it would cause like maybe some problem. [ ] So I know that there's someone speaking to me. [ ] I can't see, but I can feel."
>
> *(Martha, page 12/ lines 261-271)*

The extract suggests that Martha feels guided and influenced by God which gives her a sense of security in her daily life. Her communication with God strengthens her beliefs and determines her choice of actions to maintain her safety. Similarly, Claire expresses a personal feeling of protection from her religion in relation to her experience of mental illness.

> *Claire*: "I was too ill I wasn't [ ] consciously praying or anything like that, [ ] because I was too ill to be doing that. [ ] But I think it was there anyway [ ] erm, sustaining me. [ ] Even though I wasn't I wasn't in a state to be actively praying or doing anything like that [ ] I think erm, more almost like in a sort of erm, something was protecting me. [ ] That's-that's, that was what it was like, [ ] protective."
>
> *Interviewer*: [ ] "How did that make you feel, to have that protection?"
>
> *Claire*: "Well I think erm, probably at the time I didn't realise it, [ ] it's only looking back I can see [ ] that it was like erm, it's like you know something was watching over me."
>
> *(Claire, page 35/ lines 850-872)*

Claire and Martha share the feeling that they are worthy of God's close attention which suggests a positive impact on their feelings of inclusion and self-worth. It is important to Claire to feel protected particularly when she is

unwell and therefore unable to pray. Claire refers to 'angels' and 'invisible guides' in other parts of her account which she believes exist to ensure her safety.

Farida's description of her spirituality echoes the feeling of personal protection. Farida explains:

> "But for me it is a spiritual thing. [ ] Believing that, erm, you can have good and bad times and that someone's looking looking after you."
>
> *(Farida, page 34/ lines 654-658)*

For Farida, protection and security comes from the personal relationship she has with God. Despite Farida's struggle with her religion, she is similar to other respondents in her description of feeling that she is looked after by God. This account captures the idea of optimism and hope during 'bad times'. The description suggests that when she is struggling, Farida's beliefs give her something to hold onto which provides her with a sense of safety.

Protection in the form of saving life has been expressed by Martha and is an experience which is also shared by Claire.

> "I don't know if I would have come so far [ ] after being ill from 1999 [ ] without the spirituality. [ ] I think it's erm, been sustaining [ ] and probably erm, life saving in the same way as the [mental health support group]'s been life saving."
>
> *(Claire, page 23/ lines 565-573)*

The use of 'sustaining' and 'life saving' suggests Claire's dependence upon her beliefs for survival. Claire's feeling of protection differs slightly from other participants in that it exists alongside the non-religious intervention from the

mental health support group. Claire sees herself as protected both by her religion and by her support group with her repetition of 'life saving' which positions her as a survivor of illness. Ideas around protection which have saved her life seem to suggest a positive impact on Claire's sense of self in an uncertain world in which her survival has been threatened.

Bella adds to this way of thinking that spirituality has saved her life through the provision of protection and security. In the context of her experience of mental illness, Bella explains:

> "If it wasn't for Jesus coming to earth, setting the example of how to pray, I would be dead by now. Jesus saved me. He walked with me every day. He guides me with his angels that surround me."
>
> *(Bella, page 9/lines 160-162)*

The extract highlights the severity of mental illness which would have resulted in ending Bella's life. Similar to Claire, Bella refers to her belief in the protection she feels from angels. The words 'he walked with me every day' suggests that her experience of mental illness was a long emotional journey during which she has felt continually supported by Jesus. The act of walking together suggests a close relationship at a gentle pace towards a destination of recovery, which leads Bella to a sense of security. Bella's recognition that her life was worth saving suggests the positive impact of spirituality on her self-esteem and the sense of hope in choosing to continue with life.

Spirituality appears to provide a sense of security in the belief of protection from mental illness. Thomas describes the protection provided by his spirituality in the following extract.

> *Thomas*: "It means a safe guidance through life [ ] and, a deliverance out of the state of being unwell. [ ] When I'm feeling well it's a stability [ ] to stay well."
>
> *Interviewer*: "And how does it help you to stay well?"
>
> *Thomas*: "Well it keeps me out of trouble and it keeps me out of danger when I can follow my faith. [ ] 'Cause sometime I do get carried away when I get too angry that I get lost for a while [ ] and them times do worry me. [ ] But, I have to always, I always go back to my faith [ ] and it safeguards me through life."
>
> *(Thomas, pages 6-7/ lines 103-119)*

Thomas' reference to a 'safe guidance' suggests his spirituality provides a structure for living with the purpose of protecting him from harm. Thomas is positioned as a person who has greater mental stability in his life with the involvement of spirituality, particularly with his use of the word 'deliverance' which reinforces the idea that spirituality offers him salvation from illness. Thomas' beliefs serve the purpose of taking him 'out of' the situation of ill health which appears to suggest that his spirituality provides a means to becoming well.

In addition, Bella appears to share the experience of feeling protected from mental illness by her spiritual beliefs. As Bella says:

> "Practicing my faith means, it means the world to me because it's something to hold onto when I'm going through that hard times. When I feel like I'm being, coming under attack. [ ] From the enemy, 'cause that's how I see it as, its the enemy [ ] Trying to attack me."
>
> *(Bella, page 34/ lines 609-614)*

The idea of ‘something to hold onto’ suggests the stability that Bella feels from her beliefs. Bella’s vulnerability as a victim of her mental illness is described in the situation of ‘coming under attack’ which is a reference to her experience of hearing voices. Referred to as ‘the enemy’ rather than an illness, Bella sees her symptoms as something which she needs to fight against. Her illness is experienced as a personal attack which illustrates the powerful effects of mental illness upon her feeling of security. The intense distress from the challenge of mental illness is reflected by her hesitancy within the account ‘being, coming’. Bella’s spiritual beliefs have immense significance and provide her with protection in the form of strength to fight the attack which positions Bella as a survivor of her mental illness.

In summary these extracts illustrate the range of ways in which spirituality can be understood as a protective factor within the experience mental health problems. Spiritual beliefs can provide some people with a feeling of safety and for others, a sense that they are protected from mental illness. Protection from the distress of mental illness can have a positive impact on self-worth and hope for the future. A personal sense of security leads to the overall sense of feeling complete as a person. The next emergent theme addresses a sense of control in life.

5.6.2 Emergent theme: Keep level headed: A sense of control

Spirituality appears to bring greater control in life through support with decision making. All participants articulate a sense of control from spirituality

which helps them to live with the uncertainty of mental illness. Martha describes the benefits of praying when she feels 'upset' which results in 'a change of heart'.

> "You know because if I'm upset or anything and I go down and pray, it's like I have a change and I would say I'm going to do this thing, and then I'm going to do and the moment I go and pray, when I get up off my knee or if, if I'm in bed, I have a change of heart. [ ] I don't feel like doing the thing that I said I was going to do."
>
> *(Martha, pages 9-10/ lines 205-209)*

The quotation demonstrates that a 'change' appears to occur to Martha's thinking process as a direct result of her decision to pray. The change is from a state of distress to a clearer state of mind which brings control over difficult emotions and helps to shape her decisions. In the context of her role as a mother, living in the UK away from her family in Jamaica and struggling financially to raise her children, there is a need for Martha to feel control. It appears that Martha's beliefs bring guidance to cope with distress which ultimately leads to peace and control in her life. The extract positions Martha as a person who is empowered by her faith.

Claire shares the idea about turning to religion for support with decision making as she talks about praying 'for strength' to help her to 'make the right choices'. Claire's experience differs from the other participants as she relies upon the advice from a religious booklet which can been seen in the following extract.

> "I did bring it today actually, it's just a little booklet which is called the 'Word for Today' [ ] Erm and what it is, it's a little, what, what, how it helps me is that I read the erm, the advice on it and it also gives you a scripture to read, erm, and, I've got I

> read this, for almost, since when I, I found it at one of - one of the churches when I was - when I was unwell. [ ] And I've read it for as long as I've been ill. I've-I've signed up for it. [ ] It just gives you a little bit of erm, a little-little sort of, different sort of erm, thing, message to think about. [ ] And then it gives you like the scriptures to read and I've found that very helpful. I've found the erm, the organisation [name] very helpful. They're sometimes, when I've been in, in a crisis I've phoned their prayer line [ ] which I've found useful. [ ] So it's, it's what I like about this little booklet [ ] is it's about practical everyday things. It's not sort of, erm, out, it's not sort of, erm, far from, you know [ ] in a world of it's own. [ ] It relates to everyday life. [ ] And I find that very useful. I try and read that everyday [ ] Erm, and then it, I feel [CLEARS THROAT] I feel like I've erm, I feel like I've been strengthened by reading."
>
> *(Claire, pages 9-10/ lines 207-237)*

> "Sometimes what-what what's written is exactly like your life circumstances. [ ] Sometimes it isn't but you can still take something from it."
>
> *(Claire, page 10/ lines 243-245)*

There are a number of important points within this extract. Although described in simple terms as 'just a little booklet' the document is critical to Claire's daily spiritual practice and her sense of control. On the day of the interview, Claire had chosen to bring the booklet with her. Claire herself brings the booklet to the forefront of the discussion which demonstrates the strong significance of its meaning to her spiritual beliefs. She has retained the booklet since becoming unwell which demonstrates its importance. Reading the booklet is a daily activity that provides an element of structure and focus to Claire's life, which is significant in a routine that may be lacking in structure. Her commitment to her routine represents her commitment to her religion. What is important to Claire is the booklet is a source of practical advice and support to which she can relate. Claire describes feeling 'strengthened' by reading which suggests a greater level of control as a consequence of the opportunity for reflection and focus which may be associated with reading. The booklet is a symbol of control

as it provides Claire with answers to problems and support to face difficult situations. As a consequence, Claire has the ability to make informed decisions in her life and therefore cope with her illness.

In summary the quotations show the variations in the relationship between spirituality and the experience of control. A sense of control can bring peace where life has been disrupted by mental illness. Control is also seen in relation to a level of independence and empowerment which leads to feeling whole as a person. The third emergent theme relates to a sense of purpose in life.

5.6.3 Emergent theme: Helped me to identify who I was: A sense of purpose

This theme addresses the role of spirituality in finding a sense of purpose. All of the participants talk about spirituality in a way that suggests that it is the cornerstone of their identity and provides a purpose in life. Bella explains:

> "Like because, as you grow up, and if you face like depression [ ] you can, you feel lonely. And you don't know where you belong. You haven't got no identity of where you belong, where you came from, [ ] where you're supposed to go, what you're supposed to be doing. [ ] And when I found Christ [ ] as a child, [ ] and growing up maturing into Christianity [ ] [COUGHS] that helped me to identify who I was in Christ."
>
> *(Bella, page 12/ lines 211-224)*

A sense of identity is clearly important to Bella as she refers to the issue herself, identity was not introduced during the interview questions. She describes a

strong sense of vulnerability due to a lack of direction and belonging, which points to the degree to which mental illness and her childhood have undermined her sense of identity. Bella appears to have developed her sense of identity and an understanding of her experiences as a result of her religion. In the following extract, Bella describes her views on Jesus in relation to her experience.

> "He died for us. He paid, he paid the price for our sins [COUGHS] And, I could relate to that because as a child, things had happened to me [ ] I I was abused and stuff like that so, I felt like he he suffered and I had suffered and I had somebody to relate to [ ] And because I had somebody to relate to, I felt safe."
>
> *(Bella, pages 6-7/ lines 105-110)*

It is clear from her response that Bella feels a deep connection with Jesus through the shared experience of suffering. Religion has given Bella 'somebody to relate to', which suggests a person with whom to identify her suffering. Bella's identity was previously defined by abuse and harm but now is defined by her religion which has helped her to change her outlook on life and positions Bella as a survivor. The idea that she is not alone in her experience is powerful as it gives Bella the means to make sense of her suffering and therefore develop a sense of hope and purpose for living. The hesitancy in her speech highlights the difficult emotions associated with the topic. The deep emotional scars from the abuse during childhood have eroded her identity but Bella has rediscovered who she is through her religion which helps her to feel 'safe', suggesting that she has regained personal control and purpose in life.

Bella also constructs her identity from reading Bible stories. The experience of reading the Bible gives Bella direction when facing her problems which is illustrated in the following extract.

> "Cause in this life, people don't tell you how to survive. But the Bible does when you start to read it. [COUGHS] So that's how I gain comfort. [ ] Because, for every problem in my life, I've been able to read stories in the Bible and relate to it. [ ] And if I don't relate to it, I can pick out a situation in the Bible and understand it from God's perspective [ ] to show me in my life, to set an example so I don't make a mistake."
>
> *(Bella, page 17/ lines 307-314)*

Bella highlights the personal significance of reading the Bible in her ability to 'relate to it' as a means of coping with all of her problems. The extract is an insight into how Bella views her life experiences, her difficulties and the solutions to her problems in order to 'survive'. It is the Bible rather than people that Bella perceives as a reliable source of support. The Bible gives personal meaning to her specific circumstances and helps Bella to make sense of herself and her illness.

Again, Bella succeeds in finding 'something to relate to' when reading psalms. Her description highlights her ability to identify her personal experience with her religion.

> "And when I read psalms, I felt like anything what I needed was coming from the book [ ] What I was experiencing and how I was feeling, it was in psalms. So I had something to relate to, I had something to give me comfort [ ] I had something to reassure me that I wasn't alone and that God understood anything [ ] I could just turn a page in the Bible and it would understand."
>
> *(Bella, page 35/ lines 636-641)*

What clearly emerges from the extract is the strong sense that Bella feels acceptance and 'comfort' from God when reading psalms which fulfils her unmet need for reassurance and understanding. The idea of feeling understood carries great significance in the context of living with hearing voices and limited family support. In turn, Bella is able to accept and understand her experience which helps to secure her sense of identity.

Similarly, Claire adds to this way of thinking. Claire says:

> "And the psalms as well are very useful. Because erm, the psalms again they're, they're like the erm, the 'Word for Today' in that they can relate to, although they're written a thousand years ago, they can relate to your specific circumstance [ ] They do say I think, there's a psalm for every circumstance."
>
> *(Claire, page 13/ lines 306-310)*

Claire develops an understanding of her experience and identity through reading psalms. The use of 'relate to' and 'specific circumstance' continues the suggestion of the personal significance of religion which lessens Claire's feeling of isolation in her experience. Claire identifies herself within the psalms which gives her the opportunity to reflect upon the message and apply it to her situation. Consequently, reading provides Claire with comfort and hope when living with mental illness. Religion appears to give Claire clarity about herself which has an impact upon how she understands her illness and her identity.

A sense of purpose is important for Claire which is expressed in her 'focus' on religion each day. She articulates a daily feeling of purpose which is linked to the ways in which she practices her faith.

> "It's something that erm, I focus on, try and focus on, erm, give all my energy to at least once every day [ ] with the-with the-with the erm, guidance of the [name of organisation] [ ] So that I'm reading something spiritual, I'm reading my Bible every day. [ ] Also as I go about the day, I'm sort of, praying and praying for strength [ ] praying for guidance [ ] on a daily basis."
> *(Claire, page 25/ lines 606-617)*

Claire's dedication and commitment to her beliefs is illustrated by the emphasis of her entire 'energy' which she channels into reading 'at least once every day'. This suggests the substantial personal investment that Claire places in reading her Bible which is a critical part of her daily routine, a structure which brings purpose to Claire's life. Claire seeks solace in reading which gives her guidance and direction, helping her to cope with her illness.

For Martha, identity and purpose comes from her personal relationship with God. Her individualised connection with God gives her an outlet in which to confide when she is feeling unwell. Martha describes her feelings in the following extracts.

> "Sometimes when I'm feeling depressed, [ ] I know that I've got someone there [ ] I can talk to. You know I can pray, communicate, and when I do that, I feel much better. [ ] If I don't do that, I will be thinking this and I will be thinking that you know. [ ] Yeah yes. So I think I would be hopeless without, [ ] without my belief in God."
> *(Martha, pages 26-27/ lines 589-599)*

> "You know because if I'm feeling down, or I'm feeling low, [ ] the first thing come in my mind, is to talk to God. [ ] If it's even to say, Lord have mercy upon me, [ ] Lord remember me. You

> know, you know I'm not well today, you promised that you would heal. [ ] You know I feel, I feel better so it helps me, [ ] with this illness. [ ] If I, if I had a mental illness, and I wasn't a Christian [ ] I I think I would be out of my mind completely."
>
> *(Martha, page 32/ lines 714-730)*

Martha's beliefs give purpose to her life which would otherwise leave her feeling 'hopeless' and lacking in direction. Her religion fulfils an unmet need by giving her the opportunity to communicate how she is feeling and gives her the sense that her problems have been heard. The extracts highlight Martha's need to express her distress as there is always 'someone' to listen to her problems which helps her to feel 'much better'. Martha feels comfortable to speak openly about her innermost feelings which helps her to cope with her illness. Martha describes how praying to God helps distract her from ruminative thinking as she suggests 'I will be thinking this and I will be thinking that' in the absence of prayer.

The personal significance of talking to God is highlighted in the words 'the first thing come in my mind'. Martha's first line of defense when experiencing mental illness is to seek help from God so that she is not facing her problems alone. Martha's confidence that her contact with God is reliable is suggested in her words 'I know I've got someone there'. The knowledge that she can talk to God helps Martha to feel accepted and appears to give her the sense of companionship. Her religion appears to provide a reliable support system which helps her to 'feel much better'. Although Martha is supported by her family, she chooses to turn to God initially when depression affects her purpose and identity which suggests the high level of trust that Martha places in

her beliefs. Talking to God about her problems helps Martha to move on with her life to rediscover her purpose and direction.

In addition, Bella adds to this way of thinking as she describes the benefits of speaking directly to God.

> "And nomatter what I do, I can always come up with, like I'm having an incident in my life, say somebody hurts me, I can look in the Bible and see how that situation was dealt with by God and how it can help me by praying over my life. And praying to God to say 'Lord can you help me with this situation.' Because I'm finding it very difficult and I need your help, I need your strength. I need your support right now."
>
> *(Bella, page 52/ lines 954-957)*

Bella continues the suggestion that her spirituality addresses an unmet need of feeling heard and understood. Her relationship with God is one that is reliable as she is able to request help instantly. The meaning of spirituality for Bella therefore is support in the form of a personal relationship through difficult times.

Similarly, Farida's account of her spirituality suggests that she seeks purpose and meaning which is linked to a sense of control in her life. In the following extract Farida envisages that she would 'be lost' in a life without spirituality.

> *Interviewer*: "So for you, what do you think your life would be like without your religion or your spirituality?"
>
> *Farida*: [SIGHS] "I'd be lost."
>
> *(Farida, page 32/ lines 602-604)*

In response to the question, Farida's initial sigh reflects an expression of despair. She is limited in the support networks she can draw upon and is therefore reliant upon her religion for direction and purpose, yet her relationship

with her religion is complex. Farida's response implies that she fears a life of uncertainty and vulnerability in the absence of her spiritual beliefs.

Thomas shares a similar response to the same question by stating that his life without spirituality would be a 'waste'. Thomas envisages a sense of loss in his life in the following quotation.

> "Waste [ ] Mmm, no direction [ ] and because of no direction, no motivation."
>
> *(Thomas, page 9/ lines158-162)*

The extract highlights the drive and hope for the future which Thomas gains from his beliefs. Thomas is clearly dependent upon his beliefs to keep him going through life which positions him as vulnerable without his spirituality. As a result, his religion is a dominant part of his purpose in life and his identity.

This theme addresses how spirituality can be understood as a key element of personal identity and seeking purpose in life. Spirituality plays a crucial role for some people in helping to feel understood when the symptoms of mental illness may be difficult to comprehend.

In summary what clearly emerges from the data is the importance of spirituality to each of the participants. The meaning of spirituality is unique to each person and what is central to the accounts is the role of religion as a source of support. In addition, the interviews reflect the difficulties of living with isolation and disempowerment and as a consequence, spirituality appears to be a coping mechanism for dealing with loss and the experience of mental illness.

During periods of mental illness however, religion also becomes a source of confusion in relation to the inability to focus upon reading and praying. The relationship with spirituality therefore changes according to the specific mental health needs of the individual. Overall, spirituality provides a sense of security, control and purpose which enables people to feel complete. The following table provides a detailed presentation of the themes.

Table 5.3 Master Table of Themes for All Cases

Super-ordinate Themes	Page/line
a. Controlled relationship with spirituality	
The things that are important to me: The meaning of spirituality	
P5 Claire: you can be spiritual just by being in touch with the outdoors, the sun or nature or things like that	1/16-19
P1 Farida: its always been there	28/533
P2 Bella: it means the world to me	34/609
P4 Martha: well God love me and God don't reject me	29/663
P3 Thomas: it's within me	2/20
I'm not handling it well: Negative effects of spirituality	
P1 Farida: I find it really hard to actually pray	7/115
P4 Martha: my religious belief, it was, when I'm ill, it's sort of a barrier	19/435
P3 Thomas: I find it too overwhelming	26/481
b. Experience of loss	
I'm in turmoil: Living with disempowerment	
P1 Farida: I don't know who I am anymore	10/169-170
P2 Bella: If it wasn't for Jesus coming to earth, setting the example of how to pray, I would be dead by now.	9/160-161
P3 Thomas: rather than navigating through life, life was navigating me	4/69-71

P4 Martha: things was hard P5 Claire: I got knocked down by a motorbike and I thought I was gonna die	13/297 7/151-156
No one can understand you: Living with isolation	
P2 Bella: you've got nobody to turn to, you've got no role model or nobody who understands. P4 Martha: People will reject you P5 Claire: I haven't really found the Church where I felt that I was at home in P3 Thomas: I don't talk about it P1 Farida: I've never told anyone I get help	13/236-240 29/658-661 11/268 19/340 52/972
c. Feel like a whole person	
It's God's protection: A sense of security	
P2 Bella: it's something to hold onto when I'm going through that hard times P3 Thomas: It means a safe guidance through life P4 Martha: God has got a mark on me P5 Claire: I just don't think I'd have made it through without the faith P1 Farida: someone's looking after you	34/609-610 6/103 16/348 34/842 34/657-658
Keep level headed: A sense of control	
P2 Bella: I'm choosing to be a Christian P4 Martha: if I'm upset or anything and I go down and pray P5 Claire: I feel like I've been strengthened by reading P1 Farida: I've made some changes in my life	45/825 9/205 10/236-237 11/183
Helped me to identify who I was: A sense of purpose	
P5 Claire: it's something that I can focus on P2 Bella: I don't feel lost anymore P4 Martha: I would be hopeless without my belief in God P1 Farida: I'd be *lost*. I think you need it.	25/606 14/259 27/597-599 32/604

In the next chapter I present the findings of the IPA research in the context of the wider literature to explore the implications for mental health practice.

Chapter 6

Discussion

"…*I just don't think I'd have made it through without the faith, it was like a support system…that I needed and it was essential*."
(Claire 34/832-846)

The personal spiritual beliefs of an individual may be fundamentally essential when facing mental illness. This chapter will discuss the specific findings of this IPA research and examine how the findings might relate to theory from other contexts to develop understanding on the provision of meaningful holistic mental health care. The significant contribution of IPA is highlighted by Smith, Flowers and Larkin (2012: 38) in which the detailed consideration of the idiographic analysis can shed light on the existing research from wider contexts. Firstly, I consider the discussion around the structure of the research question and the three research aims by placing the superordinate themes within the context of the wider literature. Secondly, I consider recommendations for mental health practice, nursing education and policy. Finally, I examine a reflexive view of the research process, followed by the recommendations for further research. The next section provides the research question together with the research aims and summarises the findings from this IPA research and the systematic literature review.

Research question: What does spirituality mean to BME people with mental health problems?

Research Aims:

- To understand the unique lived experience of spiritual beliefs in relation to BME people living with a mental illness.
- To explore the role spirituality plays for BME people with mental health problems.
- To advance scholarship in the area of spirituality and mental health from a UK perspective.

In response to the research question, table 6.1 presents the findings from this IPA study alongside the themes which emerged from the systematic literature review. The shaded areas indicate the gaps within the existing literature which are addressed by the findings of this research and are therefore discussed in the next section.

Table 6.1 A comparison of the findings from my research with themes from the systematic literature review

Themes from my IPA research	Themes from the systematic literature review
a. Controlled relationship with spirituality	
The things that are important to me: The meaning of spirituality	Theme 5: Personal meaning Theme 2: Support for living Theme 3: Connection with God Theme 1: Enhancing well-being and recovery
I'm not handling it well: Negative effects of spirituality	Theme 4: Negative aspects of religion
b. Experience of loss	
I'm in turmoil: Living with disempowerment	
No one can understand you: Living with isolation and judgement	Theme 4: Negative aspects of religion
c. Feel like a whole person	
It's God's protection: A sense of security	Theme 3: Connection with God Theme 1: Enhancing well-being and recovery Theme 2: Support for living
Keep level headed: A sense of control	Theme 1: Enhancing well-being and recovery Theme 2: Support for living
Helped me to identify who I was: A sense of purpose	Theme 5: Personal meaning Theme 3: Connection with God Theme 1: Enhancing well-being and recovery Theme 2: Support for living

The table illustrates that there were a number of similarities between the findings from this IPA study and the findings from the current literature in relation to the meaning of spirituality, the negative aspects, the sense of security, control, identity and purpose. The differences that emerged were that the superordinate themes of a '*controlled relationship with spirituality*', the '*experience of loss*' and '*feel like a whole person*' did not appear as explicit major themes in the systematic literature review which indicates the contribution to knowledge development of this study. These similarities and differences in the findings will be discussed in this chapter, beginning with addressing the first research aim.

6.1 Discussion of Research Aim: To understand the unique lived experience of spiritual beliefs in relation to BME people living with a mental illness.

A number of themes emerged from the participants' accounts that revealed the lived experience of spirituality and mental health to address the above research aim. The superordinate themes of a '*controlled relationship with spirituality*' and the '*experience of loss*' together with the emergent themes of '*the meaning of spirituality'* and the '*negative effects of spirituality*' were identified as key components of the experience which will be discussed in this section.

6.1.1 Controlled relationship with spirituality

The analysis of the participants' accounts demonstrated first and foremost the complexity of spirituality within the context of living with a mental illness. A central finding here was the suggestion by some participants that the relationship with spirituality was one which was dynamic and change occurred in spiritual beliefs according to the individual experience of mental illness. Negative effects of spirituality were experienced by some which consequently required a fluid relationship with their spiritual beliefs. Martha, Farida and Thomas described the steps that were taken to carefully control their relationship with spirituality which was specific to their unique needs.

When mentally unwell, Martha experienced confusion when reading the Bible which she recalled as ‘sometimes it affects my head more.’ A similar finding was presented in a study by Mohr, Brandt and Borras et al (2006: 1957) which looked at religious coping among 115 outpatients with psychosis. One of the participants described feeling disturbed as a negative effect of reading the Bible which is consistent with Martha’s experience. While describing the importance of her religion, Martha stated ‘when I’m ill, it’s sort of a barrier’ therefore, for these reasons Martha controlled her relationship with spirituality by distancing herself from her religion during periods of mental ill health.

Similarly, Farida described a sense of confusion about her religious beliefs and distanced herself from her religion which she stated ‘doesn’t work’ when she feels mentally unwell. In studies conducted by Heffernan, Neil and Thomas et al (2016; Lilja, DeMarinis and Lehti et al 2016; Starnino and Canda 2014), it was found that participants with mental illness struggled to engage in religious activities as a result of poor concentration levels and fatigue, the consequences of which were feelings of loneliness, failure and detrimental effects upon mental health. The findings from the literature concerning poor concentration levels resonate with the findings presented here however, the outcomes differed for Martha and Farida as they described greater mental health rather than poorer mental health resulting from a distanced relationship with their spiritual beliefs.

The analysis demonstrated another layer of complexity in Martha's controlled relationship with her spirituality. Martha reflected on the essential role of psychiatric medication rather than reliance on her belief in God to improve her mental health during an episode of illness, as she stated, 'my Christianity couldn't help me because I was out of my mind'. Psychiatric medication enabled Martha to regain control over her relationship with spirituality and engage with religious practice. This finding is consistent with a phenomenological study by Vanderpot, Swinton and Bedford (2018) who researched the relationship between spirituality and psychiatric medication. Interviews were carried out with twenty participants and findings revealed that although the symptoms of mental illness disrupted the ability to participate in spiritual practice, medication enabled participants to re-engage in spiritual activities which enhanced spirituality and mental health recovery. The findings from Martha's experience suggests that the effects of psychiatric medication are a key aspect of spirituality.

In contrast to the experiences of Martha and Farida, Thomas controlled his contact with his spirituality during episodes of mental stability in which his experience of spirituality was 'overwhelming'. The concept of changes in spirituality is one which few studies have considered however, this finding is in line with phenomenological research completed by Lilja, DeMarinis & Lehti et al (2016) in which interviews were conducted with seventeen participants in Sweden with experience of mental illness. The findings identified the importance of a dynamic relationship with God which changed over time to

support the recovery of the individual. Furthermore, Wilding, Muir-Cochrane and May (2006: 150) suggest from their phenomenological study in Australia of six participants with mental illness that the journey of spirituality is one in which spiritual beliefs do not remain static and can change due to the changing experience of mental illness. The analysis indicates that for some people spiritual beliefs are not static and the way in which beliefs may change are specific to the individual concerned.

These findings expand upon relevant wider literature which has explored the meaning of spirituality beyond the mental health population. In a UK study, Cassar and Shinebourne (2012) conducted IPA research using semi-structured interviews with four participants who identified themselves with a spiritual orientation. The analysis revealed that spirituality was experienced as a journey through life which moved with the person. Similarly, McInnes Miller and Van Ness Sheppard (2014) explored the meaning of spirituality through conducting surveys with 141 graduate students in the USA. From the study it emerged that spirituality was a fluid experience that shifted and changed with the person's life experiences. These findings shed light on the recommendations within the literature to acknowledge with sensitivity the idiosyncratic qualities of each spiritual story (Mohr, Brandt & Borras et al 2006: 1958). Exercising control over the relationship with spirituality is for some people crucial to their mental health and is therefore a key component of the unique lived experience of spirituality.

This section has so far highlighted the complex nature of spirituality which is evident within a distanced relationship with personal beliefs which may occur either during periods of feeling mentally well or unwell, after which individuals may choose to reconnect with their personal beliefs. Spiritual and religious beliefs may appear confusing due to the symptoms of mental illness therefore an individual may struggle to engage with their spirituality due to poor concentration levels. Through alleviating the symptoms of mental illness, psychiatric medication may play a critical role in enabling people to reengage with spiritual and religious practice. In relation to mental health practice, clinicians therefore require a broad understanding of spirituality in order to provide meaningful support.

6.1.2 The things that are important to me: The meaning of spirituality

When questioned about the meaning of spirituality, the participants' accounts revealed that the lived experience of spirituality encompassed a broad range of meanings which included religion, support, personal values, creativity and nature. Each participant had an individual understanding of religious or spiritual beliefs therefore despite the identification of common themes within the analysis, what was striking in the accounts was that the lived experience of spirituality was unique to each person.

These findings support ideas that spirituality is uniquely experienced by each individual. Wilding, Muir-Cochrane and May (2006) found that each participant with mental illness held a unique understanding of spiritual beliefs.

This is consistent with the findings of a study by Russinova and Cash (2007) who interviewed forty individuals with serious mental illnesses in the USA and found each participant held nuanced variations of spiritual beliefs. The specific meaning of spirituality is therefore varied, personal and unique to each individual which is a significant feature of the lived experience.

One of the meanings of spirituality was the important role of beliefs when dealing with the experience of ill health. Martha and Claire described their experiences of becoming drawn towards religion as a result of facing serious health problems. Martha explained 'I passed out when I died and God brought me back', an experience which led Martha to become a Christian. Claire's experience was similar in which she described that she started to 'pray to be grateful to be alive' which was in relation to an accident whereby she believed that she was going to die. In addition to facing physical health problems, the onset of Claire's mental illness drew her closer to her spirituality which she recalled as feeling 'closer to that higher power'. These narratives of spirituality which became meaningful as a consequence of facing illness are not explicit within the literature however, only one study (Wilding, Muir-Cochrane and May 2006: 147) previously noted that the importance of spirituality was initiated for the participants by the experience of becoming mentally unwell.

In addition, there are parallels with an IPA study conducted by Wilde and Murray (2009) in which near death experiences were explored. Interviews were conducted with three participants and from the analysis it emerged that

each participant discovered a new understanding of life which was meaningful for them as an outcome of their near-death experience. These findings reflect those reported by Martha and Claire in their realisation that spiritual beliefs enabled them to cope with the effects of illness. The importance of understanding how the unique meaning of spirituality fits within the context of a person's life experiences is confirmed once again within this thesis research.

Another meaning of spirituality for the participants was the sense of support which led to a greater sense of personal control and was therefore, a key component of the lived experience of spirituality. Support was evident in a variety of ways and for some involved a connection with God. In contrast with the concept of a controlled relationship with religious practices, spiritual activity in the form of prayer and reading the Bible was highlighted by Bella and Martha as important features of their spiritual lives which enabled them to connect with God and provided a source of support for coping with psychological distress.

These findings are reported in previous studies which have identified support gained from religious practice as a common theme in the literature. Heffernan, Neil and Thomas et al (2016) interviewed ten participants with the experience of psychosis and found that engagement with religious scriptures and rituals provided a source of support which was critical to sustaining mental health recovery. In addition, research by Sullivan (1993) in which forty participants with mental illness were interviewed found that prayer and reading the Bible was essential to coping with mental illness. Similar findings were

discovered by Green, Gardner and Kippen (2009) who conducted phenomenological research with six participants in Australia in which the important role of prayer emerged as a spiritual need which supported recovery from mental illness. Furthermore, research in Malaysia by Nabil, Saini and Nasrin et al (2016), which interviewed ten participants with depressive disorder, concluded that the ability to engage in worship was an essential need. The experiences of Bella and Martha therefore illuminate the findings from current research.

Alternatively, Claire sought support from sources which were unique to her experience which is a reminder of the distinct features of spiritual practice. Claire found benefits from watching Christian television channels which made her feel 'that you are not alone'. In addition, Claire contacted a prayer telephone line and read a religious booklet from which she felt 'strengthened' and in greater control of her decision making. A similar finding was revealed in a UK study by Bhui, King and Dein et al (2008) which looked at religious coping among ethnic groups. One participant connected to God through listening to Christian radio which helped her to make sense of her experience. The impact of personal beliefs upon coping skills is evident in other research. Das, Punnoose and Doval et al (2018: 238) looked into spirituality and coping skills with forty-eight patients with schizophrenia in India in which it was revealed that spiritual and religious beliefs positively influenced coping skills to deal with the effects of mental illness. The findings reflect the significant meaning of religious practice which provides guidance for individuals who identify with religion. The

analysis and current literature demonstrate that for some individuals, spiritual practice may be a double-edged sword which at times can be a barrier to mental health and at other times a coping mechanism in the form of emotional support, which emphasises the complexity of the unique lived experience and the need for the person to be in control of their relationship with spirituality.

The analysis revealed that the meaning of spirituality extended beyond religion. Farida related her spirituality to her personal values and 'morals'. For other participants, creativity was a key element to the meaning of spirituality. Bella described her experience of writing poetry which she felt 'came from God to me' and therefore provided her with a connection to God. A similar experience was expressed by Claire who wrote poems and songs which she described as 'one of the strongest areas' of her spirituality. In addition, Claire's spirituality involved a sense of connection with nature whereby she identified the activity of running in the park as a place 'where the spirituality starts' in which she observed the change of seasons throughout the year.

The current literature resonates with many of the findings presented here concerning a broad meaning of spirituality. Chan and Ho (2017) conducted a grounded theory study with eight participants with schizophrenia in Hong Kong and reported that spirituality was associated with personal beliefs and values. Similarly, Russinova and Cash (2007) found that spirituality was associated with values and moral principles which was important in the approach to life and relationships with others which is consistent with Farida's narrative.

In relation to the roles of creativity and nature as key elements of the lived experience of spirituality, a sense of connection with nature was identified by participants in studies by Miller and Sheppard (2014) and Russinova and Cash (2007). Furthermore, Green, Gardner and Kippen (2009) revealed that participants' spirituality drew upon a range of strategies which included creative activities and connections with nature to improve mental health well-being. In addition, the findings of Starnino and Canda (2014) in a phenomenological study of eighteen participants demonstrated that a meaningful connection to nature was beneficial in terms of recovery for people with severe mental illness. These findings reflect the experience of a personal connection to various elements of spirituality which were reported by Claire and Bella to be significant factors for their mental health and key features of their unique lived experience.

6.1.3 Experience of loss

Participants' accounts suggested that spirituality had a role to play in dealing with the experience of loss within the context of living with the effects of mental illness. A sense of loss was expressed by each participant in unique ways in relation to disempowerment and living with isolation and judgement. Thomas recalled his lack of power during his experience of hospital treatment. In addition, a sense of isolation and lack of support in hospital was described by Bella in which she needed her Bible because she 'needed something to rely on' as a mechanism for coping. For Bella, disempowerment was also as a consequence of living with the uncertainty of relapse in which she was 'scared of the voices coming back'. Furthermore, Bella's lack of power was evident in

the context of her role and identity which was expressed in her statement 'I believe I should have had a career by now'.

Farida's disempowerment was expressed in relation to her not being heard as she described 'they don't even listen' at a time when she was in need of mental health support from health care professionals. Although support and coping with mental illness are common themes throughout the literature, few studies have considered spirituality as a way of coping with the experience of disempowerment in relation to mental illness which is a key feature of these narratives. The finding of loss is however, consistent with research conducted by Young (2015) which included six participants with mental illness in Hong Kong whereby the feeling of profound loss was reported by all the participants in relation to becoming mentally unwell. In addition, Wilding, May and Muir-Cochrane (2005: 5) reported that mental illness was experienced as a crisis event which led to feelings of hopelessness and therefore, relates to the experience of loss in the lives of the participants.

A sense of loss was expressed by Farida who touched on issues associated with ethnicity. Loss was described in the form of isolation from her family due to the stigma surrounding mental illness in which she stated her mother-in-law would have been 'absolutely ashamed' with the knowledge of Farida's mental illness. Outside of her family, Farida described facing prejudice towards her religion and as a consequence, was strongly against the idea of discussing her spiritual needs with mental health professionals which was

evident in her words ‘I would have hated it’. This finding is similar to the findings of Heffernan, Neil and Thomas et al (2016) who identified the significance of personal choice and control in terms of making the decision to combine religion with mental health care. The study found that some participants believed that religion and mental health were separate issues and integration should not be forced due to the fear of prejudice from others either towards religious beliefs or mental health which sheds light upon Farida’s narrative.

Conversely, Koslander and Arvidsson (2006, Harris, Nienow, Choi et al 2015) found that mental health patients actively wanted to discuss their spirituality with mental health nurses in order to address their spiritual needs which suggests that Farida’s account is in contrast to the literature. The distinct context for Farida not wanting to discuss her spirituality is her fear of prejudice towards her religion, Islam. The specific socio-cultural context highlights the need for mental health practitioners to be sensitive to such issues to understand the unique complexities of the relationship between spirituality and mental health for each individual.

The sense of loss was reported in relation to a feeling of isolation and a loss of support from others. Isolation was experienced by Bella which was evident in her description of having ‘nobody to turn to’. Her isolation was reinforced by her difficult family relationships in which Bella’s family perceived her to be ‘brainwashed’ by her spiritual beliefs. In the absence of family

support, Bella sought help from a Church however she didn't feel 'a sense of belonging' and continued to feel isolated. Claire reported a similar experience in which her spiritual beliefs created separation from her family and she had also struggled to find a church where she felt 'at home'. These findings indicate that Bella and Claire experienced a profound sense of isolation from involvement with religious communities.

The experiences of Bella and Claire are similar to the findings of Starnino and Canda (2014) where participants revealed that they faced stigmatisation by religious communities. Similarly, Mohr, Brandt, Borras et al (2006) discovered that participants reported a lack of support from religious groups as a result of their mental illness despite regular religious engagement. In contrast, studies by Heffernan, Neil and Thomas et al (2016) and Sullivan (1993) found that religious communities provided a space for acceptance, belonging and social support. These studies suggest the socio-cultural factors of belonging within religious communities as a form of social support, yet variations in the sense of belonging and acceptance of the person can help or hinder their relationship with the mental illness and their spirituality. The literature did not acknowledge the relationship between family relationships and spirituality however, the findings raise the question concerning the level of support provided by spiritual and religious groups which can lead to either positive or negative effects, the impact of which needs to be understood in the unique circumstances of each person.

To summarise this section, the meaning of spirituality that has emerged in this research echoes the definitions of spirituality in the literature which include a broad range of personal meanings such as a connection with religion, values, nature and creativity (Puchalski, Vitillio and Hull et al 2014, RCPsych 2013). Despite these similarities, this study has indicated that the unique experience of spirituality for each individual is more complex than suggested by the definitions. Farida's perspective highlighted her fear of prejudice towards Islam and her fear of stigma towards mental illness from within her community. At times spirituality may have negative effects which can be a barrier to mental health and at other times, spiritual beliefs may be a supportive coping mechanism for dealing with the experience of profound loss and mental distress. Consequently, this study has found that for some people, the relationship with spirituality is not static and the way in which beliefs may change are specific to the individual experience of mental illness which emphasises the complexity of the unique lived experience. The next section will focus on how the findings have explored the role of spirituality for BME people with mental health problems.

6.2 Discussion of Research Aim: To explore the role spirituality plays for BME people with mental health problems.

The superordinate theme of '*Feel like a whole person – sense of wholeness*' revealed the role of spirituality for the participants which addresses the above research aim. The role played by spirituality was revealed within the emergent themes of '*It's God's protection: A sense of security*', '*Keep level*

headed: A sense of control' and '*Helped me to identify who I was: A sense of purpose*' all of which contributed to a sense of feeling whole. Each of these themes will be discussed in relation to the wider literature in the next section.

6.2.1 It's God's Protection: A sense of security

The participants suggested that a central element of the role of spirituality was the provision of a sense of security and protection which was experienced in a range of different ways. Farida made reference to the feeling of personal protection from her spiritual beliefs that someone 'is looking after you', while Thomas indicated that his spirituality kept him 'out of danger'. One of the key findings of the study was that spirituality had saved lives which was not only identified by Martha in her account of God saving her from death but also reflected in Bella's narrative which highlighted her sense of support from her religion, 'If it wasn't for Jesus coming to earth…I would be dead by now. Jesus saved me.' In addition, Claire referred to her spirituality as 'sustaining' and 'life saving' which illustrated the protective role of her beliefs. This finding has parallels with the studies by Heffernan, Neil and Thomas et al (2016) and Wilding, May and Muir-Cochrane (2005) in which it was reported that spirituality was essential to sustaining life and protected participants from suicide. The narratives highlight the vital importance of spirituality in sustaining and protecting the lives of individuals and therefore, its role of contributing a sense of hope which is significant for mental health recovery.

6.2.2 Keep level headed: A sense of control

The participants reported a sense of control which contributed to feeling whole as a person. Guidance and support were sought from religious beliefs in order to face problems which led to increased levels of empowerment. Martha was supported with decision making through prayer in which she described 'a change of heart' after praying and equally, Claire sought support from her religion to 'make the right choices' when dealing with problems. The narratives reflect the findings reported in the wider literature whereby guidance was well documented as a theme in several studies (Beagan, Etowa, and Bernard 2012, Heffernan, Neil and Thomas et al 2016, Keefe, Brownstein-Evans and Polmanteer 2016, Wilding, May and Muir-Cochrane 2005: 5) from which strength was found to cope with difficulties which was beneficial to mental health recovery. The role of spirituality for Claire and Martha was found therefore, to provide a sense of control to cope with mental illness which is consistent with the findings of existing literature.

6.2.3 Helped me to identify who I was: A sense of purpose

Another identified feature of the role of spirituality was the inter relationship between the development of personal identity, the provision of meaning and purpose in life and having a genuine relationship with God and religion. Bella recalled her experience of lacking identity and belonging however, through her religion she 'had somebody to relate to' which gave meaning to Bella's experiences and helped her to construct her identity. Bella felt acceptance and 'comfort' both from talking to God and reading the Bible

which developed her sense of identity and was significant in the context of limited family and church support.

The importance of a personal connection with God or a Higher Power in connection with meaning and purpose in life has been highlighted as a feature of spirituality in various ways by previous studies (Beagan, Etowa and Bernard 2012, Cassar and Shinebourne 2012: 136, Heffernan, Neil, Thomas et al 2016, Raftopoulos and Bates 2011, Russinova and Cash 2007, Starnino and Canda 2014: 280). The significance of Bella's personal relationship with God is similar to the findings of Heffernan, Neil and Thomas et al (2016) in which it was found that a genuine connection with God was crucial to the meaning of religious activity and played a significant role in mental health recovery.

For Martha, her identity and purpose were secured from her personal relationship with God. Martha described talking directly to God in which she stated, 'I know I've got someone there', and the 'love' she felt from God which was a key element of her spirituality. The importance of an individual connection with God during the experience of mental illness was highlighted by Lilja, DeMarinis and Lehti et al (2016) in which the participants described talking to God and feeling a presence when mentally unwell which helped to alleviate the sense of loneliness and is consistent with Martha's experience. Similarly, Sorajjakool, Aja and Chilson et al (2008) found that a personal relationship with God was significant to the meaning of spirituality and provided participants with comfort, meaning in life and a sense of protection. In addition, Mohr, Brandt

and Borras et al (2006) found that religion provided mental health patients with a sense of compassion, comfort, identity and meaning which is consistent with the findings of this study. Furthermore, Bhui, King and Dein et al (2008) found that the African Caribbean participants in their study perceived their connection with God as an individual relationship that was a source of support when facing difficulties which is in line with Martha's narrative. The findings suggest therefore, that the role of spirituality is to provide a sense of connection with God and for others, a sense of connection with nature as previously mentioned which is a central strategy for some individuals in relation to coping with mental illness.

This section has discussed how the findings have addressed the research aim to explore the role of spirituality. Spiritual and religious beliefs can enable the person to feel whole through providing a sense of security, control, guidance, identity and purpose. For some, spirituality may sustain life and contribute to a sense of hope which is important for mental health recovery. Across the themes, an individual connection with God played a key role in coping with mental illness. The next section will discuss spirituality and mental health from a UK perspective to address the final research aim.

6.3 Discussion of Research Aim: To advance scholarship in the area of spirituality and mental health from a UK perspective.

This section of the chapter will discuss the implications of the findings from a UK perspective by considering how this study on the lived experience of spirituality can translate into meaningful mental health practice and the implications for nursing education, policy and future research.

6.3.1 Implications for practice

The findings of this study contribute towards a deeper understanding of the experience of spirituality and mental health which has profound implications for mental health practice. The use of IPA has captured the rich diversity of spiritual experience which has elicited key insights into spirituality and mental health. The focus of this study was to give voice to BME participants yet issues concerning ethnicity did not emerge as dominant issues in relation to spirituality. The main finding of this research suggests the complexity of spirituality which was experienced uniquely by each participant alongside the emergence of common themes which have a significant impact upon mental health. The understanding that the experience of spirituality is subjective and diverse may inform progression in mental health practice whereby clinicians are better positioned to recognise the unique interaction between spirituality and mental health and therefore can provide more meaningful support.

Spirituality within mental health care remains neglected (MHF 2008) despite the clear focus on the spiritual dimension of a holistic, person centred

approach by healthcare policy (DH 2006, DH 2011) and professional bodies (NMC 2018: 13, RCPsych 2008). Financial cuts to mental health services make it difficult for staff to take the time to provide this aspect of care however, the value of this study has been to show the vital importance of spirituality in the lives of people who are struggling with mental illness which sheds light on the need for spirituality to have a central place in current mental health practice. Spirituality may enable a person to feel whole and can play a significant role in mental health recovery. A failure to address the topic may imply that a person's needs and fundamental mechanisms for coping are devalued and ignored. It is therefore, important that clinicians dedicate more time to pay close attention to the spiritual and religious beliefs of individuals to provide comprehensive care. Mental health professionals need to be willing and open to having conversations with clients in order to carefully listen and take seriously their spiritual beliefs and practices to understand what is fundamentally important to each individual.

The findings suggest that there are a number of issues within the inherent complexity of spirituality which must be translated into the practice of mental health assessment and interventions. Firstly, the broad meaning of spirituality which emerged from the distinct accounts of each participant suggests that mental health professionals must clearly and emphatically adopt a person-centred approach to attend to spiritual needs. The approach must harness a wide perspective of what spirituality can include which could indicate sources of support for coping with psychological distress and dealing with the

experience of profound loss. The experiences of loss identified in this study expand upon Repper and Perkins' (2004: 48-51) notion that people with mental illness are recovering from a range of traumas associated with a sense of loss, the loss of a sense of self, loss of power, loss of meaning and loss of hope which are not fully recognised by mental health professionals. Practitioners must understand the complex meaning of spirituality in relation to mental health support.

Secondly, an understanding of the unique context of a person's spiritual and religious beliefs is required which may be crucial to developing a rich insight into the importance of personal beliefs. In some cases, participants were drawn towards spiritual and religious beliefs because of traumatic experiences in which spirituality provided significant coping strategies for living with mental illness and sustaining life. The case of Farida is a reminder that not all people are comfortable with the idea of discussing their spirituality as part of mental health support. Farida's account also shows that the socio-cultural background from which the person comes can act as a barrier to self-expression of religious and spiritual needs. Mental health workers must learn from alternative experiences such as Farida's to acknowledge that some people may not want to participate in spiritual discussion concerning their mental health yet for others, engagement with religious activity may be critical to mental health recovery.

In addition, it is important that as part of mental health assessment and interventions, professionals sensitively explore the nuanced relationship with

spirituality with the clear understanding that for some people, the connection with spirituality is controlled and does not remain static. Furthermore, the role of psychiatric medication must be recognised which may have a positive impact upon spiritual practice. To explore the idiosyncratic meaning of spirituality, mental health nurses need to help clients to tell their own spiritual story (Mohr, Brandt, Borras et al 2006: 1958) the challenge however, is to develop mental health care in which it becomes common practice to intimately listen to the personal narratives of each individual in mental health services as part of holistic care.

Personal storytelling is recognised within the 'Tidal Model' of mental health recovery (Barker and Buchanan-Barker 2005) which is an approach to mental health care in which the person's personal story lies at the heart of practice in order to access the person's lived experience of distress. Holistic assessment aims to explore 'who' the individual is with the primary emphasis being on allowing the person to tell their narrative which is documented entirely in the person's own words and empowers the individual's voice (Barker and Buchanan-Barker 2005: 11-13). Similarly, Nurser, Rushworth, Shakespeare et al (2018) looked at the experience of personal storytelling as a mental health intervention in an IPA study with eight participants and found that personal storytelling can be a meaningful part of mental health recovery which empowered individuals. It is important to consider therefore, that attention in mental health care should be refocussed to the value of personal stories which

perhaps will allow individuals to share their personal meanings of spirituality and mental health and contribute towards more meaningful holistic care.

The concept of an individualised approach to exploring spiritual needs can also be examined from the perspective of Person-Centred Counselling which was pioneered by Dr Carl Rogers (Rogers 1995). At the heart of this approach is the emphasis on the client's internal world and the belief that within all individuals lies the resources for development and self-understanding (Mearns and Thorne 2010: 1-10, Rogers 1995: 115). National healthcare policies often refer to person-centred care as fundamental to holistic care provision, yet it should be noted that although the term is widely used, the concept is quite distinct from Rogers' approach to person-centred counselling. A framework for person-centred nursing is described by McCormack and McCance (2006) which comprises four inter-related elements; the attributes of the nurse, the care environment, delivering care through a range of activities and the expected outcomes of person-centred nursing. The emphasis is upon nursing practice to develop therapeutic relationships and to guide decision-making about care which does not refer to the specific elements of person-centred counselling developed by Rogers.

In relation to person-centred counselling, Rogers described the core conditions of genuineness, acceptance and empathic understanding that are necessary to develop a therapeutic relationship. Empathic understanding involves the counsellor's ability to perceive the internal world of the client from

the client's perspective and understand the personal meanings of the client's experience (Mearns and Thorne 2010: 17). This study highlights that sensitive exploration of a person's spirituality can provide the opportunity for a truly person-centred approach to care. Perhaps mental health practice needs to return to the core conditions of person-centred counselling to explore the personal meaning of spirituality for the individual and the internal spiritual resources for growth.

In addition, person-centred counselling is consistent with the sense of control which is provided by spirituality. Rogers (2015: 150) describes the locus of evaluation which refers to the source of choices, decisions and judgements which are made about a person. Initially in client-centred therapy, the locus of evaluation is externalised whereby the person is vulnerable to the evaluations made from others which are placed on the individual (Mearns and Thorne 2010: 15-16). The person increasingly comes to recognise that the locus of evaluation becomes internalised whereby the individual learns that judgements and guidance lie within internal resources which the person can trust and control, rather than grasping the evaluations from outside made by other people. Rogers (2016: 119) states that the person recognises that decisions and choices rest internally rather than seeking approval or guidance for decisions from others. The locus of evaluation suggests a growing sense of control and independence which has parallels with the sense of control gained from spiritual beliefs and indicates that a person-centred approach may play a

key role in meaningful mental health support in which clinicians understand each person as an individual.

Similarities exist between the features of spirituality and the concept of recovery in mental health. Recovery is an approach in mental health practice which is defined as a deeply individual process of searching for meaning and purpose in life beyond the impact of a mental illness (Anthony 1993). Recovery involves a personal journey of redefining the self and developing coping strategies. The principles of recovery are that individuals with mental illness are first and foremost people with an identity that is separate from the illness, rather than perceived as symptoms or 'patients' (Anthony 2003). The fundamental concepts in recovery are a sense of connection, restoring hope, optimism, personal identity, finding meaning and purpose in life and a sense of empowerment and control (Leamy et al 2011) all of which reflect the common themes reported by the participants in this study which highlights the important role of spirituality in recovery. Clinicians must therefore pursue the close links between spirituality and mental health recovery and be supportive of people who choose spirituality as part of their individual recovery journey.

In summary, so far this section has discussed the complexity of spirituality which has a number of implications for mental health practice. As a consequence of these implications, the recommendations for practice, nursing education and policy are provided in the following section.

6.4 Recommendations for practice, education and policy

1. **Consideration should be given to the way in which spirituality is taught within nursing education**.

The spiritual domain of care is an NMC professional requirement for pre-registration nursing education (NMC 2018: 13). Although spirituality is already part of the nursing curriculum, the teaching style needs to prioritise attention to the complexity of spirituality and the individualised approach to spiritual care that is required in practice which has been highlighted in this research. Current research known as the 'Enhancing Nurses Competence in Providing Spiritual Care through Innovative Education and Compassionate Care' (EPICC) project by McSherry, Ross, Giske et al (2017) is in the process of exploring spiritual education for pre-registration nurses and midwives across Europe to develop best practice. The teaching of spirituality in both theory and clinical placement settings must recognise the key concepts of personal beliefs which are consistent with the Recovery approach to mental health and person-centred counselling in order to equip mental health nurses with the appropriate skills.

2. **The personal context of spirituality needs to be considered in mental health assessment and interventions.**

Mental health workers need to consider the complex meaning of spirituality which is distinct to each individual. During assessment and interventions, clinicians must recognise that for some people, the experience of spirituality is changeable and may be influenced by the symptoms of mental illness. Mental

health professionals must also consider that some people may feel strongly against discussing their spiritual needs as part of their mental health support.

3. **Practice providers to prioritise spirituality as a key component of mental health support.**

It is recommended that there is greater emphasis in current health care policy and clinical practice to recognise the vital importance of spirituality within mental health care. Consideration must be given to the implications of greater resources for funding and staffing levels to enable clinicians to take the time that is needed to understand the unique spiritual needs of each individual.

4. **Promote an environment where spiritual conversation is encouraged through personal storytelling.**

Mental health professionals need to recognise the value of personal storytelling as an approach to understanding the spiritual needs of a person. The clinician needs to enable the person to have a voice to express their spiritual concerns and recognise that the approach is consistent with the principles of the Tidal Model, mental health Recovery and person-centred counselling.

6.4.1 Reflexive considerations on the research process

Through completing this study, I have learned about the principles of IPA research and the vital importance of understanding the lived experience for knowledge development. Through my individual journey into this IPA study, I have learned to appreciate the complexity of human experience. Listening to

the participants' accounts helped me to realise that ordinarily in mental health services, we only touch upon the surface in our assessments. I believe that the experience of undertaking this IPA research has helped me to become a better Mental Health Nurse with the focus upon listening to the person in order to understand each unique lived experience. This study contributes to knowledge development through using IPA to give voice to individuals from a BME background who are dealing with mental illness which promotes the inclusion of spirituality in the conversation on holistic mental health support. The participants have given a unique insight into the personal meaning of spirituality within their lives therefore, the outcome has clearly demonstrated insight into the research question which is to understand the unique lived experience of spirituality and mental health. The detailed analysis of each person's experience has been a strength of the research which has facilitated my reflection on current mental health practice in relation to spirituality.

The limitations of the study are that only individuals from a religious background participated in the research which is suggestive of a possible selection bias. The individuals who participated in the study may have actively sought to be involved as a result of being better adjusted to spirituality rather than those who did not engage with the research. Due to the IPA commitment of the study, the sample size is small therefore the findings are specific to this particular group of individuals and generalisations with the wider mental health population are limited. The findings are suggestive for mental health practice and consequently, further research to include a variety of perspectives from a

diverse range of people including non-religious individuals would deepen the understanding of spirituality and mental health.

An additional limitation may be the use of a single interview which each participant. A second interview may have allowed the opportunity to clarify key points and delve further into the significance of spiritual issues. Alternatively, perhaps exploring the topic using other creative research methods could have enabled participants to express their perspectives. Gough and Lyons (2016) discuss the benefits of innovative qualitative data collection in which different forms of knowledge can be generated through techniques such as photographs taken by the participant or using objects which are personally significant to the individual. It is argued by Brinkmann (2015) that interviews are over used therefore, greater use of creative and imaginative qualitative inquiry should be pursued. Methods such as Photovoice which combine photography and writing have been used in a study to capture the meaning of recovery for people with serious mental illness (Mizock, Russinova and Shani 2014). Based upon these considerations, the following section provides recommendations for further research.

6.5 Recommendations for future research

Recommendation 1: The experience of spirituality for other diverse groups who are living with mental illness.

All the participants were religious and from one particular area of the UK. This study has contributed an understanding of the lived experience of spirituality for

these participants however, further development is required to explore the experiences of spirituality of diverse populations including non-religious individuals and other religious groups from wider geographical areas across the UK.

Recommendation 2: To explore the lived experience of spirituality using creative research methods.

Further research is needed to explore the meaning of spirituality for people who are living with mental illness using innovative approaches which are essential to high quality research and the generation of new insights into the phenomena of spirituality.

In summary this chapter has discussed the key research findings through participant quotes and relevant theory to address the research question. Key recommendations have been made for mental health practice, education, policy and future research. The next chapter provides the conclusion to the research.

Chapter 7

Conclusion

> *'If you don't know who I am, how are you going to provide a package of care for me to deliver something? When you do not know how important my religion is to me, what language I speak, where I am coming from, how are you going to help me cope with my mental illness? And that is what I am trying to get over to people; the first step is about identity. It is absolutely fundamental to the package of care we offer an individual.*'
>
> (Professor Kamlesh Patel).

The value of personal beliefs in relation to mental health care and identity is clearly captured in the above statement made by Professor Kamlesh Patel, former Chair of the Mental Health Act Commission (Mulholland 2005: 5). Mental health problems are a global health concern (Vos, Barber and Bell et al 2013) and in order to treat mental illness, it is recommended by the World Psychiatric Association that the importance of the relationship between personal spiritual beliefs and mental health is understood (Moreira-Almeida, Sharma and van Rensburg et al 2016: 87). In this chapter I conclude the thesis through considering the contribution to knowledge towards the evolving understanding of spirituality and mental health by drawing together the key themes of the previous chapters in connection with the findings of this research.

This study set out to explore the meaning of spirituality to BME people with mental health problems. The research question and aims were driven by the current literature in chapter one which revealed the recognition by

professional bodies and policy frameworks of spirituality as a vital element of health care however, spiritual needs remain neglected as a consequence of the challenges to providing spiritual care. The gap within the current literature indicated that little is known about spirituality from the perspective of people facing mental illness which led to the systematic review of the literature in chapter two. The systematic review identified five themes from 41 studies which illustrated the positive and negative features of spiritual experience for individuals with mental health problems, yet few papers included the voice of BME participants.

This research has therefore, contributed to knowledge development by giving voice to individuals with mental health problems from a BME background. The research methodology and the research methods to explore the meaning of spirituality was explored in chapters three and four. IPA was selected to understand the meaning of the human lived experience of spirituality and dealing with mental illness. The interpretative focus aimed to make sense of the powerful patterns of meaning within the accounts. The idiographic approach gave voice to the unique perspectives of Farida, Bella, Thomas, Martha and Claire, all of whom have highlighted the vital importance of understanding a person's spirituality in the context of mental health.

In addition, the research has contributed to new knowledge by demonstrating the immense complexity of spirituality and mental illness from the unique perspectives of the participants. In chapter five the richly detailed

analysis of the personal accounts of spirituality produced three super-ordinate themes; *Controlled relationship with spirituality*; *Experience of loss* and *Feel like a whole person* which highlighted positive and negative aspects within the meaning of spirituality. A key finding of the study was that spiritual beliefs are highly individualised regardless of religious denomination. The experience of spirituality is nuanced and, for some people, unique changes in beliefs may occur as a result of mental illness.

In chapter six, the IPA themes were discussed in connection with the wider literature which shed light on the current knowledge of spirituality from a different perspective. Although similarities were identified with the literature, the superordinate themes did not appear as explicit themes within the systematic review which indicates a contribution to knowledge development. The study indicated that the unique experience of spirituality is more complex than the definitions provided in the literature. The concept of an individualised approach to mental health support is consistent with the principles of person-centred counselling and mental health recovery which are at the heart of spiritual care. The implications for developing mental health practice and the recommendations for future research have been made.

I conclude that this research expands current knowledge on the meaning of spirituality to people with mental health problems. This greater understanding may be of benefit to individuals with mental health problems and mental health professionals in what remains an uncertain part of mental health

care. It appears that spiritual and religious beliefs can play a beneficial role for some people though providing a range of coping mechanisms while others may experience negative consequences associated with spiritual beliefs. Such experiences may illuminate sources of personal meaning which may strengthen person centred mental health care therefore, it is crucial that a person's spiritual needs are not overlooked. From the findings, I suggest this would indicate that particular attention in mental health care should be given to the nuanced meaning of spirituality and that individual differences should be taken into consideration as part of mental health support. It seems that a mental health nurse who understands the particular spiritual needs of an individual who is struggling with mental illness can make a valuable contribution to help the person move towards mental health recovery.

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Appendix 1 CASP Appraisal Tool for Qualitative Research

Appendix 2

Table 2.5 Studies selected based on the title and abstract.

Abstract number	1	2	3	4	5	6	7	8	9	10
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Type of study Qualitative?	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Action Include (read full article) or Exclude	Exclude	Include	Include	Include	Include	Exclude	Include	Include	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	11	12	13	14	15	16	17	18	19	20
Population People with mental health problems? Adult patients?	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	x	x	✓	✓	✓	✓	x	✓
Type of study Qualitative?	✓	✓	x	x	✓	✓	✓	✓	x	✓
Action Include (read full article) or Exclude	Exclude	Include	Exclude	Exclude	Include	Include	Include	Include	Exclude	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	21	22	23	24	25	26	27	28	29	30
Population People with mental health problems? Adult patients?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Action Include (read full article) or Exclude	Include	Include	Exclude	Include	Include	Include	Exclude	Include	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	31	32	33	34	35	36	37	38	39	40
Population People with mental health problems? Adult patients?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	✓	Unclear	✓	✓	✓	✓	✓	✓	✓	✓
Action Include (read full article) or Exclude	Include	Include	Exclude	Include	Include	Include	Include	Include	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	41	42	43	44	45	46	47	48	49	50
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	x	✓	x	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	✓	x	✓	x	✓	✓	✓	✓	✓	✓
Action Include (read full article) or Exclude	Include	Exclude	Include	Exclude	Include	Include	Include	Include	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	51	52	53	54	55	56	57	58	59	60
Population People with mental health problems? Adult patients?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Action Include (read full article) or Exclude	Include	Include	Exclude	Include	Include	Include	Include	Include	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	61	62	63	64	65	66	67	68	69	70
Population People with mental health problems? Adult patients?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	✓	✓	x	✓	✓	x	✓	✓	✓	✓
Action Include (read full article) or Exclude	Include	Include	Exclude	Include	Include	Exclude	Include	Include	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	71	72	73	74	75	76	77	78	79	80
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Type of study Qualitative?	✓	Unclear	x	✓	Unclear	x	✓	x	✓	Unclear
Action Include (read full article) or Exclude	Include	Include	Exclude	Include	Include	Exclude	Include	Exclude	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	81	82	83	84	85	86	87	88	89	90
Population People with mental health problems? Adult patients?	✓	✓	Unclear	✓	✓	✓	x	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	Unclear	x	✓	✓	✓	✓	✓	x	Unclear	x
Type of study Qualitative?	Unclear	x	Unclear	Unclear	Unclear	Unclear	✓	x	Unclear	x
Action Include (read full article) or Exclude	Include	Exclude	Include	Include	Include	Include	Exclude	Exclude	Include	Exclude

Table 2.5 Studies selected based on the title and abstract.

Abstract number	91	92	93	94	95	96	97	98	99	100
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	x	x	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Type of study Qualitative?	✓	Unclear	Unclear	x	Unclear	x	x	x	✓	✓
Action Include (read full article) or Exclude	Include	Include	Include	Exclude	Include	Exclude	Exclude	Exclude	Include	Include

Table 2.5 Studies selected based on the title and abstract.

Abstract number	101	102	103	104
Population People with mental health problems? Adult patients?	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓
Type of study Qualitative?	✓	✓	✓	✓
Action Include (read full article) or Exclude	Include	Include	Include	Include

Appendix 3

Table 2.6 Studies selected based on reading the full paper

Reference	Forrester-Jones, R., Dietzfelbinger, L, Stedman, D., et al (2018)	Macmin, L., & Foskett, J. (2004)	Ho, R.T,H., Chan, C.K.P., Lo, P,H.Y. et al (2016)	Raffay, J., Wood, E., & Todd, A. (2016)	Carlisle, P.A. (2015)	Morgan, G. (2010)	Carlisle, P.A. (2015)	Yang, C.T., Narayanasamy, A., & Chang. S.L. (2011)	Young, D. (2015)	Ouwehand, E., Wong, K., Boeije, H. et al (2014)
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	x	✓	✓	✓	✓	x	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action Include (for full methodological analysis) or Exclude	Exclude	Include	Include	Include	Include	Exclude	Include	Include	Include	Include

Table 2.6 Studies selected based on reading the full paper.

Reference	Koslander, T., Lindstrom, U.A., & da Silva, A.B. (2013)	Sagan, O. (2016)	Heffernan, S., Neil, S., Thomas, Y. et al (2016)	Al-Solaim, L., & Lowenthal, M. (2011)	Lith, T.V. (2014)	Eltaiba, N., & Harries, M. (2015)	Johnsdotter, S., Ingvarsdotter, K., Ostman, M. et al (2011)	Awara, M., & Fasey, C. (2008)	Starnino, V.R., & Canda, E.R. (2014)	Wilding, C., Muir-Cochrane, E., May, E. (2006)
Population People with mental health problems? Adult patients?	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	x	✓	✓	x	✓	x	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
Type of study Qualitative?	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
Action Include (for full methodological analysis) or Exclude	Exclude	Exclude	Include	Include	Exclude	Include	Exclude	Exclude	Include	Include

Table 2.6 Studies selected based on reading the full paper.

Reference	Corry, D.A.S., Tracey, A.P., & Lewis, C.A. (2015)	Ouwehand, E., Muthert, H., Zock, H. et al (2018)	Mohr, S., & Huguelet, P. (2014)	Littlewood, R., & Dein, S. (2013)	Littlewood, R., & Dein, S. (2013)	Bhui, K., King, M, Dein, S. et al (2008)	Koslander, T., Arvidsson, B. (2007)	Wilding, C., May, E., & Muir-Cochrane, E. (2005)	Laird, L.D., Curtis, C.E., & Morgan, J.R. (2016)	Nabil, A., Saini, S.M., Nasrin, N. et al (2016)
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	x	x	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Action Include (for full methodological analysis) or Exclude	Include	Include	Exclude	Exclude	Exclude	Include	Include	Include	Include	Include

Table 2.6 Studies selected based on reading the full paper.

Reference	Keefe, R.H., Brownstein-Evans, C., & Polmanteer, R.R. (2016)	Drinnan, A., & Lavender, T. (2006)	Anderson, A.J.W., Hasund, I.K., & Larsen, I.B. (2013)	Sreevani, R., & Reddemma, K. (2012)	Sullivan, W.P. (1993)	Greasley, P., Chiu, L.F. & Gartland, M. (2001)	Awara, M., & Fasey, C. (2008)	Browne, M.Q. (2009)	Murphy, M.A. (2000)	Moller, M.D. (1999)
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	x	✓	✓	✓	x	x	x	✓
Type of study Qualitative?	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Action Include (for full methodological analysis) or Exclude	Include	Include	Exclude	Include	Include	Include	Exclude	Exclude	Exclude	Include

Table 2.6 Studies selected based on reading the full paper.

Reference	Smith, S., & Suto, M.J. (2012)	Russinova, Z., & Cash, D. (2007)	Huguelet, P, Mohr, S., Borras, L. et al (2006)	Mohr, S., Brandt, P-Y., Borras, L., et al (2006)	Salimena, A.M., Ferrugini, R.R.B., Melo, M.C.S., et al (2016)	Philips, R.E., & Stein, C.H. (2007)	Starnino, V.R. (2014)	Borras, L., Mohr, S., Brandt, P-Y. et al (2007)	Knox, S, Catlin, L., Casper, M. et al (2005)	Gockel, A. (2011)
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	x	✓	✓	x	✓	x	x	x
Type of study Qualitative?	✓	✓	x	✓Mixed	✓	x	✓	x	✓	✓
Action Include (for full methodological analysis) or Exclude	Include	Include	Exclude	Include	Include	Exclude	Include	Exclude	Exclude	Exclude

Table 2.6 Studies selected based on reading the full paper.

Reference	Cinnirella, M., & Lowenthal, K.M. (1999)	Gomi, S. Starnino, V.R., & Canda, E.R. (2014)	Kevern, P., Walsh, J., & McSherry, W. (2013)	Sorajjakool, S., Aja, V., Chilson, B. et al (2008)	Corrigan, P., McCorkle, B., Schell, B. (2003)	Starnino, V.R., Gomi, S., & Canda, E.R. (2014)	Fukui, S., Starnino, V.R., & Nelson-Becker, H.B. (2012)	Starnino, V.R. (2016)	Young, K.W. (2010)	Chan, C.K.P., & Ho, R.T.H. (2017)
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	x	x	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	x	x	x	✓	x	x	x	✓	x	✓
Type of study Qualitative?	✓	✓	x	✓	x	✓	x	✓	x	✓
Action Include (for full methodological analysis) or Exclude	Exclude	Exclude	Exclude	Include	Exclude	Exclude	Exclude	Include	Exclude	Include

Table 2.6 Studies selected based on reading the full paper.

Reference	Rohricht, F., Basdekis-Jozsa, R., Sidhu, J., et al (2009)	Heo, G.J., & Koeske, G.F. (2010)	King, M., Marston, L., McManus, S., et al (2012)	Miller, R., & McCormack, J. (2006)	Pieper, J.Z.J. (2004)	Koslander, T., da Silva, B., & Roxberg, A. (2009)	Huguelet, P., Mohr, S., Gillieron, C., et al (2009)	Mohr, S., Borras, L., Nolan, J. et al (2012)	Baetz, M., Larson, D.B., Marcoux, G. et al (2002)	Danbolt, L.J., Moller, P., Lien, L. et al (2011)
Population People with mental health problems? Adult patients?	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	x	x	x	x	x	x	x	x	x	x
Type of study Qualitative?	✓	x	x	x	x	x	x	✓Mixed	x	x
Action Include (for full methodological analysis) or Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude

Table 2.6 Studies selected based on reading the full paper.

Reference	D'Souza, R. (2002)	Yangarber-Hicks, N. (2004)	Hustoft, H., Hestad, K.A., Lien, L. et al (2013)	Green, J.E., Gardner, F.M., & Kippen, S.A. (2009)	Whiteley, C., Coyle, A., & Gleeson, K. (2017)	Prout, T.A., Ottaviano P., Tavernas, A et al (2016)	Starnino, V.R., & Sullivan, W.P. (2016)	Marsden, P., Karagianni, E., Morgan, J.F. (2007)	Lilja, A., DeMarinis, V., Lehti, A., et al (2017)
Population People with mental health problems? Adult patients?	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure Spirituality? Religion?	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcomes Experience? Perceptions? Views? Meaning?	✓	✓	✓	✓	✓	✓	✓	✓	✓
Type of study Qualitative?	x	x	✓	✓	✓	✓	✓	✓	✓
Action Include (for full methodological analysis) or Exclude	Exclude	Exclude	Include	Include	Include	Include	Include	Include	Include

Appendix 4 PRISMA Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	55
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	55
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	55,56
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	59
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	61
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	60
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	63

Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	66
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	74
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	65
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	67

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	84
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	69
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	70,74
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	86
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	74
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	88
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	84

Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	96
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	97
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	100
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit: **www.prisma-statement.org**

Appendix 5

Table 2.8 Summary of all the critiques of the included papers.

Questions for qualitative studies based on CASP framework	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7	Study 8	Study 9	Study 10
1.Was there a clear statement of the aims of the research?	2	2	2	2	2	2	2	2	2	2
2.Is a qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2	2
3.Was the research design appropriate to address the aims of the research?	2	2	2	2	2	2	1	1	2	2

4.Was the recruitment strategy appropriate to the aims of the research?	2	2	2	2	2	2	1	1	2	2
5.Was the data collected in a way that addressed the research issue?	1	2	2	2	1	2	2	2	2	2
6.Has the relationship between researcher and participants been adequately considered?	2	2	2	1	2	1	2	2	0	0
7.Have ethical issues been taken into consideration?	1	2	1	0	1	2	1	2	2	1

8.Was the data analysis sufficiently rigorous?	1	2	2	2	2	1	1	2	1	2
9. Is there a clear statement of the findings?	2	2	2	2	1	2	2	1	1	2
10.How valuable is the research?	2	2	2	2	2	2	2	2	2	2
Numerical assessment awarded by the author (maximum score is 20 points)	17/20	20/20	19/20	17/20	17/20	18/20	16/20	17/20	16/20	17/20

Table 2.8 Summary of all the critiques of the included papers.

Questions for qualitative studies based on CASP framework	Study 11	Study 12	Study 13	Study 14	Study 15	Study 16	Study 17	Study 18	Study 19	Study 20
1.Was there a clear statement of the aims of the research?	2	2	2	2	2	2	1	2	2	2
2.Is a qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2	2
3.Was the research design appropriate to address the aims of the research?	2	2	2	1	1	2	1	2	1	2

4.Was the recruitment strategy appropriate to the aims of the research?	1	1	2	2	1	2	2	2	1	2
5.Was the data collected in a way that addressed the research issue?	1	1	2	1	1	1	1	1	1	1
6.Has the relationship between researcher and participants been adequately considered?	0	0	0	0	1	0	0	0	0	1
7.Have ethical issues been taken into consideration?	1	2	1	1	0	1	0	1	1	0

8.Was the data analysis sufficiently rigorous?	2	1	1	1	1	2	2	1	2	1
9. Is there a clear statement of the findings?	2	1	2	2	2	2	2	1	2	2
10.How valuable is the research?	2	1	1	2	2	2	1	2	2	1
Numerical assessment awarded by the author (maximum score is 20 points)	15/20	13/20	15/20	14/20	13/20	16/20	12/20	14/20	14/20	14/20

Table 2.8 Summary of all the critiques of the included papers.

Questions for qualitative studies based on CASP framework	Study 21	Study 22	Study 23	Study 24	Study 25	Study 26	Study 27	Study 28	Study 29	Study 30
1.Was there a clear statement of the aims of the research?	2	1	2	2	1	0	1	2	2	1
2.Is a qualitative methodology appropriate?	2	2	2	2	1	2	2	2	2	2
3.Was the research design appropriate to address the aims of the research?	2	2	2	1	1	1	1	1	1	2

4.Was the recruitment strategy appropriate to the aims of the research?	1	2	0	1	0	1	1	1	1	1
5.Was the data collected in a way that addressed the research issue?	1	1	2	1	1	1	1	1	1	2
6.Has the relationship between researcher and participants been adequately considered?	0	0	1	0	0	0	0	0	0	1
7.Have ethical issues been taken into consideration?	1	0	1	1	1	1	1	0	0	1

8.Was the data analysis sufficiently rigorous?	0	1	1	1	0	1	1	1	0	1
9. Is there a clear statement of the findings?	1	2	2	2	1	1	1	1	1	1
10.How valuable is the research?	1	2	1	2	1	1	1	1	1	1
Numerical assessment awarded by the author (maximum score is 20 points)	11/20	13/20	14/20	13/20	7/20	9/20	10/20	10/20	9/20	13/20

Table 2.8 Summary of all the critiques of the included papers.

Questions for qualitative studies based on CASP framework	Study 31	Study 32	Study 33	Study 34	Study 35	Study 36	Study 37	Study 38	Study 39	Study 40	Study 41
1.Was there a clear statement of the aims of the research?	2	2	2	2	2	2	2	2	2	1	2
2.Is a qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2	2	2
3.Was the research design appropriate to address the aims of the research?	2	2	2	2	2	1	1	2	1	2	1
4.Was the recruitment strategy appropriate to the aims of the research?	1	1	2	2	2	1	1	2	1	2	2

5.Was the data collected in a way that addressed the research issue?	2	1	2	2	2	1	1	2	1	2	1
6.Has the relationship between researcher and participants been adequately considered?	0	0	1	1	1	0	0	0	0	0	0
7.Have ethical issues been taken into consideration?	1	0	0	2	2	2	1	1	1	1	1
8.Was the data analysis sufficiently rigorous?	1	2	2	1	2	1	1	1	2	1	1
9. Is there a clear statement of the findings?	1	2	2	2	2	2	1	2	2	1	1

10.How valuable is the research?	1	1	1	1	2	1	1	1	2	1	1
Numerical assessment awarded by the author (maximum score is 20 points)	13/20	13/20	16/20	17/20	19/20	13/20	11/20	15/20	14/20	13/20	12/20

Appendix 6 Participant Information Sheet and Consent Form

Information Sheet

Study Title: How do people with mental health problems from a Black and Minority Ethnic Background think about their spirituality?

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Hello
My name is Fazilah Twining. I work at Coventry University as a Senior Lecturer in Mental Health Nursing and I am a PhD student. I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what you can expect if you do take part. Please read the following information carefully. Talk about it with your friends and relatives and health care professionals if you wish. Ask me if you have any other questions. Please take time to decide whether or not to take part.

What is the study about?
This research is part of my PhD course at Coventry University. I am studying spirituality and mental health. Spiritual experiences of people with mental health problems are often ignored by mental health professionals. The aim of the research is to improve understanding of people's experiences of spirituality and mental health. I want to find out what spirituality means to people and what is important to people when they are facing mental health problems.

Why have I been invited to take part?
You have been invited because I want to interview people from a Black and Minority Ethnic background who have had experience of mental illness. The reason is because very few studies on this topic involve people from non-white backgrounds. I would like to interview approximately 12 people who have had such experiences.

Do I have to take part?
No. It is entirely up to you to decide whether or not you want to take part. I will describe the study and go through the information sheet with you. If you decide to take part, you will be given this information sheet to keep. You will also be asked to sign a 'consent form'. If you decide to take part, you are still free to stop at any time without giving a reason. No questions will be asked if you stop.

What will happen if I take part?
If you complete and send back the attached reply slip, I will contact you to arrange an interview at a time that suits you. The place of the interview will be the voluntary organisation which you attend. I will try to answer any questions you may have about the interview or the study.

What would the interview be like?
I will ask you if you are willing to have the interview audio tape recorded. You will be given the 'consent form'. You only sign this form if you agree to take part in the interview. You will be given a copy of the consent form to keep.
The interview will be like a conversation in which I will help you to talk about yourself in your own words. I will ask you to answer some questions. There aren't any right or wrong answers – I just want to hear about your thoughts about spirituality. You do not need to answer any questions you don't want to.
I will ask you to talk about your experiences of spirituality. I will ask questions about what is important to you in your life and what you understand by the word 'spirituality'.

How will the researcher use the interview tape?
The audio recording of the interview made during this research will be used only for analysis by the researcher. No other use will be made of the recording and no one outside the study will be allowed access to the original recording.

How long would the interview take?
The time it takes for an interview varies, depending on how much you have to say. Most interviews last at least an hour. Remember, if you want to stop the interview at any time, you can do so without giving any reason at all.

What if I decide to withdraw after the interview has taken place?
You are free to leave the study at any time during the interview. If you decide to leave after an interview has taken place, all tapes and the typing of your interview would be destroyed. You will have up to 1 month after the interview to withdraw from the study.

What would happen after the interview?
I will label the interview with a code number and type out everything you said in the interview. The tape and the typed up record (transcript), identified only by the code number, would be kept in a secure place at the Department of Nursing, Midwifery and Healthcare Practice at Coventry University. Recordings of interviews will be deleted when they have been transcribed. I will send you a copy of the interview transcript for you to think about if there is anything you

would like to change or remove. I can remove any section that you do not want me to use. You can take as long as you need to do this.

Will my taking part in the study be kept confidential?
All information you provide will be kept confidential. Only members of the research team will have access to it. Any information will have your name removed so that you cannot be recognised. The consent form will be filed separately from all other information. Information will be stored in a locked cabinet in a locked office, accessed only by the researcher. Electronic information will be stored anonymously on a password protected computer known only by the researcher. The information will be disposed of in a secure manner. I must however inform you that if you disclose information that may result in you or anyone else being put at risk of harm I may have to inform the appropriate authorities. If this situation arises I will discuss all possible options with you before deciding whether or not to take any action.

What will happen when the study finishes?
The results from this information will be presented in the thesis for my PhD. The results will also be presented at conferences and in academic publications. Extracts of your words will be used but you will not be able to be identified in any reports or articles.

Who has reviewed the study?
This study has been reviewed and ethical approval has been granted by Coventry University Ethics Committee.

Who is organising and funding the research?
I have organised the research which is part of my PhD studies. I am supported by my research supervisor based at Coventry University. I receive support with funding for my tuition fees from Coventry University.

What are the possible disadvantages and risks of taking part?
You may be asked to answer questions about your personal beliefs and experiences which may or may not be linked to a difficult time in your life. The interview may involve discussing sensitive issues which you may find upsetting. Only members of the research team will have access to the information you provide. Given the nature of the study, if is highly unlikely that you will suffer harm by taking part.
<u>If you feel upset after the interview and need help dealing with your feelings, it is very important that you talk to someone at the voluntary organisation at which you are based right away.</u>

What if there is a problem?
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What are the possible benefits of taking part?
I cannot promise the study will help you but the information I get from the study will help to increase the understanding of spirituality and spiritual care.

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Thank you very much for reading this information sheet.
Fazilah Twining

Reply slip

Name.....
Contact
details.....
.....

Participant Consent Form

Title: How do people with mental health problems from a Black and Minority Ethnic background think about their spirituality?

Purpose of the study:
Spiritual experiences of people with mental health problems are often ignored by mental health professionals. The aim of the research is to improve understanding of people's experiences of spirituality and mental health. The research aims to find out what spirituality means to people and what is important to people when they are facing mental health problems.
I wish to participate in the above named research.
I have read the information sheet for the above research and understand the following (please tick):

1. That I am free to withdraw at any time. ___
2. That all information I provide will be dealt with in a confidential manner. ___
3. Confidentiality may be breached by the researcher if information suggests that anyone may be at risk of harm (for example physical harm). ___
4. I agree that the researcher may contact me. ___
5. If I become distressed as a result of taking part in the interview, the researcher will support me to explore my preferred options for seeking help. __
6. I feel mentally well and able to take part in the study. __
   *Signed.....
   *Name (Please Print).....
   Telephone number.....
   Date.....
   **If you wish to preserve some degree of anonymity you may use your initials.*

Appendix 7 Interview Schedule

Interview Questions

Descriptive – Please could you tell me about your understanding of the term 'spirituality'?
Please tell me what spirituality means to you.
How do you define your spirituality?
Please tell me about a time that you experienced spirituality in your life.
What words would you use to describe your spirituality?
Narrative – Can you tell me what spirituality means to you?
What has been the effect of experiencing mental illness upon your spirituality?
How does your spirituality relate to your mental health?
What are your religions and spiritual beliefs?
What does practicing your faith mean to you?
Structural – How do you feel your spiritual needs are addressed in mental health care?
How would you like your spiritual needs to be addressed? By whom?
Contrast – What are the main differences between good and bad?
Evaluative – How do you feel after a bad/good experience?
Circular – What do you think your family/friends/other people close to you think about your spirituality?
Comparative – How do you think your life would be without your spirituality?
Prompts – Can you tell me a bit more about that?
Probes – What do you mean by....?
Can you tell me what place spirituality has in your life at the moment? (Prompts: what happens? How do you feel? How do you cope?
Can you tell me about a recent time when you had a spiritual experience? (Prompts: what happened? How did you feel? How did you cope?
Can you tell me how spirituality affects your mental health? (Prompts: positive or negatives)
Can you tell me how you started thinking about spirituality? (Prompts: how long ago? What do you think brought this about? Can you describe how you felt about your spirituality at that time?
Have you changed the ways you think about spirituality over time? (Prompts: in what ways?)
What would be for you a positive spiritual experience? (Prompt: can you imagine what it would feel like?)
How would you describe yourself as a person? (Prompt: how do you feel about yourself)
Has spirituality changed the way you think or feel about yourself? (prompt: do you see yourself differently now than before you had mental health problems?)
How do you think other people see you? (Prompts: partner, family, friends, work colleagues, other close people)
How do you see yourself in the future?

Topic areas for the personal experience of spirituality:

- What are the person's beliefs?
- Experience of spirituality
- How spirituality fits in with the person's life.

Appendix 8 Example of Data Analysis – Polarisation

Oppositional relationships between emergent themes. Focus upon difference instead of similarity.

Positives	Negatives
Positive relationship with God	Problematic relationship with family
Unconditional help from Christ	People judge
Companionship from God	Loneliness
Felt safe	No feeling of safety
Support	Lack of support
Sense of purpose	Felt lost
Not lost as an adult	Lost as a child
Peace	Fight
Religion	Doctors
Understanding from God	Lack of understanding from staff
God and angels	Illness and devil
Spirit self	Flesh self
Belonging to a Church was part of childhood	Difficulty in finding a church as an adult - fitting in
Bible explains mental illness	Labelled by doctors
Identity as a Christian	Lack of identity
Sense of future	Loss of future
Positive role models provided by God	People are unreliable - no role models
Shaped by God	Shaped by people
Positive family relationships	Problematic relationship with family
Help from medication	Medication doesn't solve everything
Support from hearing God	Uncertain if God spoke to her
Good voices warning against danger	Voices come from the devil
Strength to overcome problems	Depression
Needed people to pray for her	People are unreliable
Needs met by support group	Staff lack understanding
Positives of religion	Caution with people in all religions
Acceptance	Judgement
Positive attitude to others	Others can corrupt you
Support from God	Division in the family caused by religion
Help from reading the Bible, personal relationship with God	Negative experience at Christian Church
Important not to mistreat others	Experience of abuse
Faith has enabled growth	Illness has denied a career
Illness has led to stronger faith	Illness has led to regrets about life
Religion is personal choice	Disapproves of family not following the Bible
Impact of religion on life	Impact of illness on life
Trust - Supported by people at the group, supported by God	Lack of trust - Let down by people - abuse, appearance judged by church people

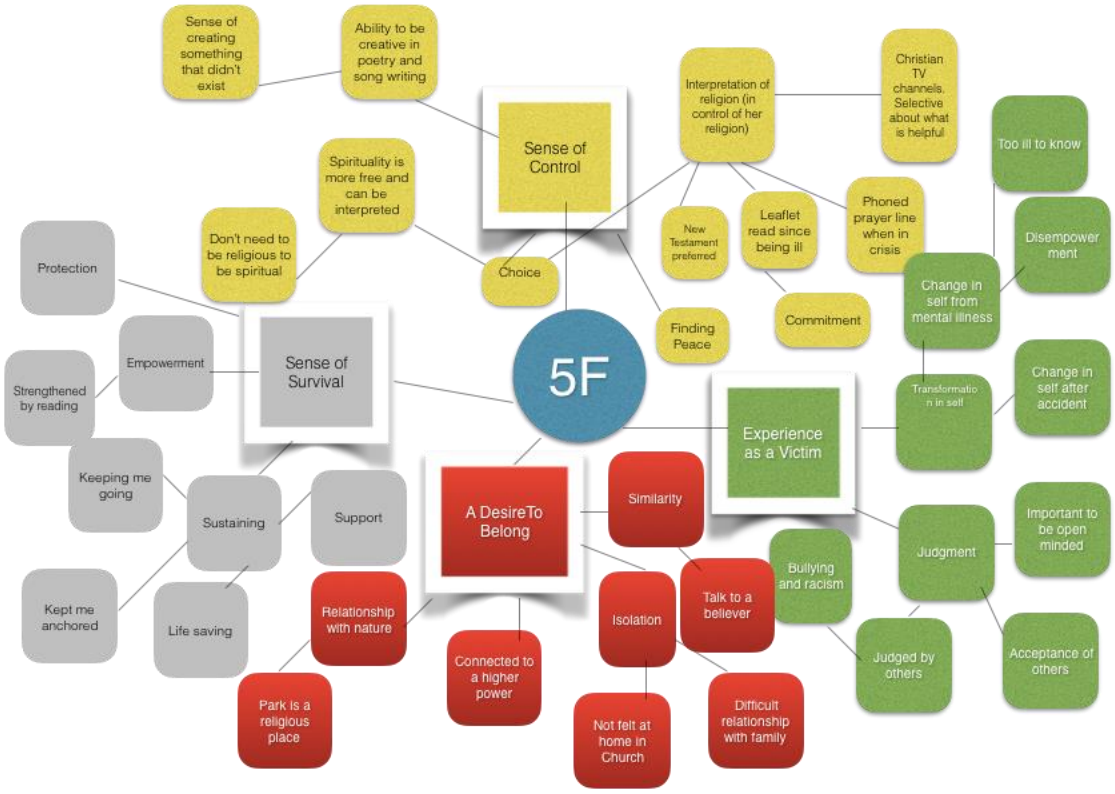
Appendix 9 Example of Data Analysis – Contextualisation

Key Event	Constellation of Themes
Road accident	Started to pray after accident
	Change in self after accident
	Thought of dying led to prayer
Bullying and racism at work	Judged by others
	Aware of other people
	Conscious of how things affect each other
	Interpretation - faith helped to understand/frame difficult experiences i.e. bullying, mental illness, road accident.
Mental illness	Change in self from mental illness
	Difficult times led to stronger faith
	Open door to a higher power
	Believe closer to that higher power
	Too ill to pray
	Sustaining me
	Protecting me
	Too ill to know
Nurse gave a Christian leaflet	Calmed me down
	Positive relationship with nurse
Found by ACCI	Keeping me going
	Kept me anchored
	Positive relationship with ACCI
	Didn’t have any support system (ie family)
Found leaflet in Church when unwell	Different message to think about
	Practical
	Useful
	Read everyday
	Reading advice and scriptures helps
	Help from booklet

Appendix 10 Example of Data Analysis – Function

Function of the emergent theme	Emergent theme
Comfort, feel safe	Support from Church
	Speak openly with God
	Prayers answered
Accepted by others	Love from God
	Personalised support
	Family understand beliefs
	Support from Church
	Feel loved
	Support during the interview
	Not isolated. Church members visit
	Singled out by God. Personal relationship
Rejection	Denied life insurance
	Expectation of God's help when mentally ill
	Doesn't want to be forgotten
Control and stability. Empowered	Protection
	Blames self for illness, not God
	Coping
	Religion has a place when well
	Strong belief
	Control over emotions
	Improved understanding of the Bible
	Became a Christian
	Change in self
	Impact of prayer on thoughts
	Religion is a permanent feeling
	Sense of wellbeing
	Religion provides hope and strength
Lack of control and stability	Difficult time raising children
	Struggled financially
	Experience of physical illness
	Experience of mental illness
	Illness affects understanding the Bible
	Strict upbringing
	Limited understanding of the Bible
	Hopeless without beliefs
	Accepts doctors help
New self	Survived physical illness
	Became a Christian

Appendix 11 Example of Data Analysis – Mindmap



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	160
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	160
Occupation	3	What was their occupation at the time of the study?	160
Gender	4	Was the researcher male or female?	158
Experience and training	5	What experience or training did the researcher have?	159
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	134
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	132
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	157
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	102
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	140
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	141
Sample size	12	How many participants were in the study?	142
Non-participation	13	How many people refused to participate or dropped out? Reasons?	142
Setting			

Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	148
Presence of nonparticipants	15	Was anyone else present besides the participants and researchers?	154
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	192
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	138,149
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	284
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	154
Field notes	20	Were field notes made during and/or after the inter view or focus group?	155
Duration	21	What was the duration of the inter views or focus group?	144
Data saturation	22	Was data saturation discussed?	182
Transcripts returned	23	Were transcripts returned to participants for comment and/or	188
Topic	**Item No.**	**Guide Questions/Description**	**Reported on Page No.**
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	187, 188
Description of the coding tree	25	Did authors provide a description of the coding tree?	n/a
Derivation of themes	26	Were themes identified in advance or derived from the data?	188
Software	27	What software, if applicable, was used to manage the data?	n/a
Participant checking	28	Did participants provide feedback on the findings?	188
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	196
Data and findings consistent	30	Was there consistency between the data presented and the findings?	252
Clarity of major themes	31	Were major themes clearly presented in the findings?	252
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	200

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

How do people with mental health problems from a Black and Minority Ethnic background think about their spirituality? P26611

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