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Abstracts

Critical Review of the Literature

This Systematic Literature Review aimed to synthesise literature reporting on symptoms of Obsessive-Compulsive Disorder in Christians, Jews, and Muslims to provide an in-depth understanding of scrupulosity symptom presentation. Keywords related to 'religion', 'scrupulosity', and 'OCD', were searched using electronic databases (PsychINFO, MEDLINE, PUBMED, CINAHL, Embase, and GlobalHealth) in March 2023. Studies which reported information about OCD symptoms on adult Christian, Jewish, or Muslim participants with scrupulosity were included. Quantitative or qualitative methodologies including case studies were screened. Studies that did not report original peer-reviewed research written in English were excluded. The quality of evidence was appraised using The Standard Quality Assessment Criteria for Evaluating Primary Research Papers, and the Joanna Briggs Institute Critical Appraisal Checklists for Case Reports, and for Qualitative Research. A narrative approach was taken to summarise obsessions and compulsions. This study is registered on PROSPERO, number CRD42023395834. Of the 4,314 records identified, 27 were eligible. The risk of overall bias varied. Differences in OCD presentations reflected theological differences in the Abrahamic faiths. In Christian samples, obsessions related to 'correct' thought and intention, in Jewish samples there was a focus on behavioural rituals, and in Muslim samples there was a focus on behavioural rituals accompanied with obsessional thoughts about faith. This review highlights the need for clinicians to be familiar with salient religious beliefs and practices when treating scrupulosity OCD.

Service Improvement Project

The Neonatal Care Unit is a challenging environment for parents. Previous literature documents the need for increased and more specialised understanding of support for fathers. There remains a dearth of literature on the experiences of ethnic minority fathers in particular, who may be less likely to access psychological support available. This project aimed to understand the barriers ethnic minority fathers faced when accessing psychology support at a Neonatal Care Unit in England. Seven fathers from ethnic minority backgrounds participated in semi-structured interviews after their babies were discharged. Data were analysed using a Reflexive Thematic Analysis approach. Three main themes were identified: '*Psychology is a Threat'*, '*It's Not Really Talked About in our Culture'*, and '*A Space for Mum, Not Me'*. These themes are discussed in reference to the extant literature, and recommendations are provided to improve access to support. There is a need to recognise interacting influences of gender and cultural norms in supporting these fathers, including understanding the role of psychology, consideration of stigma, and knowing families in relation to their cultural context.

Theory Driven Research Project

The underrepresentation of British Muslims in UK mental health services necessitates an understanding of barriers and facilitators to engagement in therapy. This mixed-methods online study explored the impact of explicitly acknowledging religion on anticipated alliance, treatment credibility, and expectations of therapy in British Muslims. A video-vignette experimental design was used in which participants who self-reported as either high or low in religiosity were randomly allocated to receiving information about Cognitive Behavioural Therapy either with or without an explicit mention of religion as a value in the therapeutic process. The results suggest that acknowledging religion does not impact upon anticipated alliance, the primary dependent variable. However, scores on the closely related secondary variables, perceived credibility of therapy and treatment expectation, were significantly higher when religion was explicitly mentioned by the 'therapist'. A thematic analysis of free text across all participants found three main themes: '*We are Too Different*', '*It's not Worth the Risk*', and '*What we Need for Therapy to Work*'. These findings suggest that mentioning religion as a value to be considered in therapy positively impacts upon how therapy is perceived by British Muslims.

Critical Review of the Literature

A Systematic Review of Obsessive-Compulsive Disorder Symptomatology in Religious People of Abrahamic Faiths: Implications for Clinical Practice

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Abstract

Purpose: This Systematic Literature Review aimed to synthesise literature reporting on symptoms of Obsessive-Compulsive Disorder in Christians, Jews, and Muslims to provide an in-depth understanding of scrupulosity symptom presentation.

Methods: Keywords related to 'religion', 'scrupulosity', and 'OCD', were searched using electronic databases (PsychINFO, MEDLINE, PUBMED, CINAHL, Embase and GlobalHealth) in March 2023. Studies which reported information about OCD symptoms on adult Christian, Jewish, or Muslim participants with scrupulosity were included. Quantitative or qualitative methodologies including case studies were screened. Studies that did not report original peer-reviewed research written in English were excluded. The quality of evidence was appraised using The Standard Quality Assessment Criteria for Evaluating Primary Research Papers, and the Joanna Briggs Institute Critical Appraisal Checklists for Case Reports, and for Qualitative Research. A narrative approach was taken to summarise obsessions and compulsions. This study is registered on PROSPERO: CRD42023395834.

Results: Of the 4,314 records identified, 27 were eligible. The risk of overall bias varied. Differences in OCD presentations reflected theological differences in the Abrahamic faiths. In Christian samples, obsessions related to 'correct' thought and intention, in Jewish samples there was a focus on behavioural rituals and in Muslim samples there was a focus on behavioural rituals accompanied with obsessional thoughts about faith.

Conclusions: This review highlights the need for clinicians to be familiar with salient religious beliefs and practices when treating scrupulosity OCD.

Keywords: Obsessive Compulsive Disorder, Scrupulosity, Religion, Christianity, Islam, Judaism

Obsessive-Compulsive Disorder (OCD) is a heterogeneous condition which causes significant impairment and distress. It is characterised by obsessions accompanied with or without compulsions (American Psychiatric Association, 2013) that relate to a range of themes including contamination, responsibility for harm, symmetry or exactness, violence, sex, morality and religion (McKay et al., 2004). When relating to morality or religion, the subcategory of '*scrupulosity'* is used, literally meaning '*fearing sin where there is none'* (Abramowitz & Jacoby, 2014). Scrupulosity obsessions may include fears of committing sin, being punished by God, or of being sent to hell. Associated compulsions may include excessive praying, seeking reassurance from religious authorities, ritualised washing, and avoidance of that which could be considered sinful.

Prevalence research finds that between 5-33% of individuals experience religious obsessions (Eisen et al., 1999; Foa et al., 1995; Mataix-Cols et al., 2002; Tolin et al., 2001). In countries where most of the population identify strongly with a faith group, the prevalence is higher, with 50-60% of individuals with OCD in Saudi Arabia and Egypt reporting religious obsessions (Mahgoub & Abdel-Hafeiz, 1991; Okasha, et al., 1994).

From a Cognitive-Behavioural perspective (Rachman, 1998; Salkovskis, 1999), OCD develops when normal but unwanted intrusive thoughts or images that are contrary to one's beliefs are misinterpreted as personally significant and threatening. While a person without OCD may recognise an unpleasant intrusive thought as insignificant, a person with OCD may believe that thoughts and actions are morally equivalent, and that having an intrusive thought means that they have sinned. They may subsequently experience doubt, distress, an urge to control or dismiss the thought, or engage in behaviour to "fix". Scrupulous individuals may attempt to perfect religious rituals to remove doubt, however,

it is not possible to attain evidence of this perfection, for example, that God has accepted their prayers (Abramowitz & Jacoby, 2014), resulting in perpetuation of their doubt and further attempts to perfect rituals.

Research suggests that expression of scrupulosity symptoms differ depending on the doctrine, beliefs, values, and sins specific to that religion (Abramowitz et al., 2004; Buchholz et al., 2019; Khanna & Channabasavanna, 1988). For example, Judaism and Islam place emphasis on behavioural traditions, purity, and fulfilment of commandments (Siev & Cohen, 2007; Beşiroğlu et al., 2012), whereas Christianity places greater importance on individual conscience and maintaining beliefs (Cohen, 2003; Williams et al., 2013). The impact of the nature of the religion on symptoms has been observed in a number of studies. In Catholic samples, participants report high levels of obsessions relating to the importance of thought control (e.g. Sica et al., 2002), in Jewish samples, handwashing rituals to avoid impurities are prevalent (e.g. Huppert et al., 2007), and in Muslim samples, there is an emphasis on cleansing of the body to prepare for prayers (e.g. Mahgoub & Abdel-Hafeiz, 1991).

Poorer outcomes for treatment of scrupulosity OCD (e.g. Ferrão et al., 2006; Rufer et al., 2005) may be understood in light of a lack of knowledge about symptom presentation, as well as religious clients' treatment preferences. Rituals may be seen as part of normal religious practice (Al-Solaim & Loewenthal, 2011), and associated with shame and stigma (Beşiroğlu et al., 2010; Glazier et al., 2015). Support is more likely to be sought from members of religious communities who may unknowingly reinforce compulsive rituals or give advice that is inconsistent with evidence-based treatment approaches (Deacon et al., 2013; Greenberg & Sheffer, 2008; Jones et al., 2019). Furthermore, perceptions that secular therapists may misunderstand legitimate religious

practices or view religious devotion as problematic may contribute to a desire to avoid seeking therapy.

Given these relational challenges, clinicians treating scrupulous individuals must be aware of gaps in their knowledge, their own biases, and the impact of these on their interactions with clients in order to avoid overlooking or ignoring important issues, conveying insensitivity, and reproducing harmful stereotypes (Williams et al., 2020). Crucially, an understanding of normal and acceptable religious beliefs and practices is needed to differentiate those from OCD symptoms. An understanding of how religious affiliation, scrupulosity, and OCD symptoms are inter-related is therefore essential to improve the assessment and treatment of scrupulosity.

Scrupulosity OCD symptoms have been described in epidemiological, cross-sectional, and case description studies in several countries and religions. These studies largely focus on participants from the three Abrahamic faiths, which have a shared core belief of monotheism, but varied doctrines and practices. As far as the authors know, there has not been a systematic review of how symptoms may differ across these religious groups. This review therefore aims to synthesise the current literature and answer the following questions to provide clinically relevant information to those working with religious clients with OCD:

(1) What are the OCD symptom profiles (in relation to scrupulosity) in different Abrahamic religious groups?
(2) What are the clinical implications for working with religious clients with OCD?
(3) What is the quality of literature in this area?

Method

Search Strategy

This systematic review followed the Preferred Reporting Items for Systematic reviews and Meta-Analyses reporting guidelines (PRISMA 20; Page et al., 2021) and a review protocol was registered in advance on PROSPERO, registration number CRD42023395834 (for more information, see Appendix A).

Papers were identified by searching the following databases via Ovid: Embase, GlobalHealth, Medline, PsycINFO; as well as CINAHL via EBSCOhost; and PubMed via the National Library of Medicine. Searches took place on the 24th of March 2023, with no restriction on publication date or language. A Boolean search strategy was used (Appendix B) and MeSH terms to combine keywords relating to OCD, Abrahamic faiths, and culture.

A 'snowball' search was also carried out on the 16th of April 2023 to identify additional studies by searching the reference lists of publications eligible for full-text review and using Google Scholar to identify and screen studies citing them. The reference lists of included studies and relevant reviews were hand searched for additional papers.

Descriptive and analytical studies were included. Given the limited literature in this area, case studies were included as they contribute relevant and clinically significant information.

Studies were eligible if they met the following criteria:

(i) Adult participants (aged 18 or over) with symptoms of scrupulosity OCD or related outcome measures.

(ii) Participants are Muslim, Jewish, or Christian.

   a. If the participants' religion was not explicitly stated but the religion was clear from details given in the results and discussion, studies were included.

   b. Studies comparing religious groups were included if data specific to religious groups could be isolated.

(iii) Reported information about OCD subtypes or symptomology.

(iv) Quantitative or qualitative methodology, including case studies.

(v) Written in English and published in a peer reviewed journal.

Studies were excluded if they met the following criteria:

(vi) Did not report novel findings or original research (e.g. letters to editors).

(vii) Published before 1980 in line with changing diagnostic criteria from 'Obsessive Compulsive Neurosis' to 'Obsessive-Compulsive Disorder'.

(viii) Referred to 'Obsessive Compulsive Personality Disorder'.

(ix) Religious clients with OCD but non-scrupulosity symptoms.

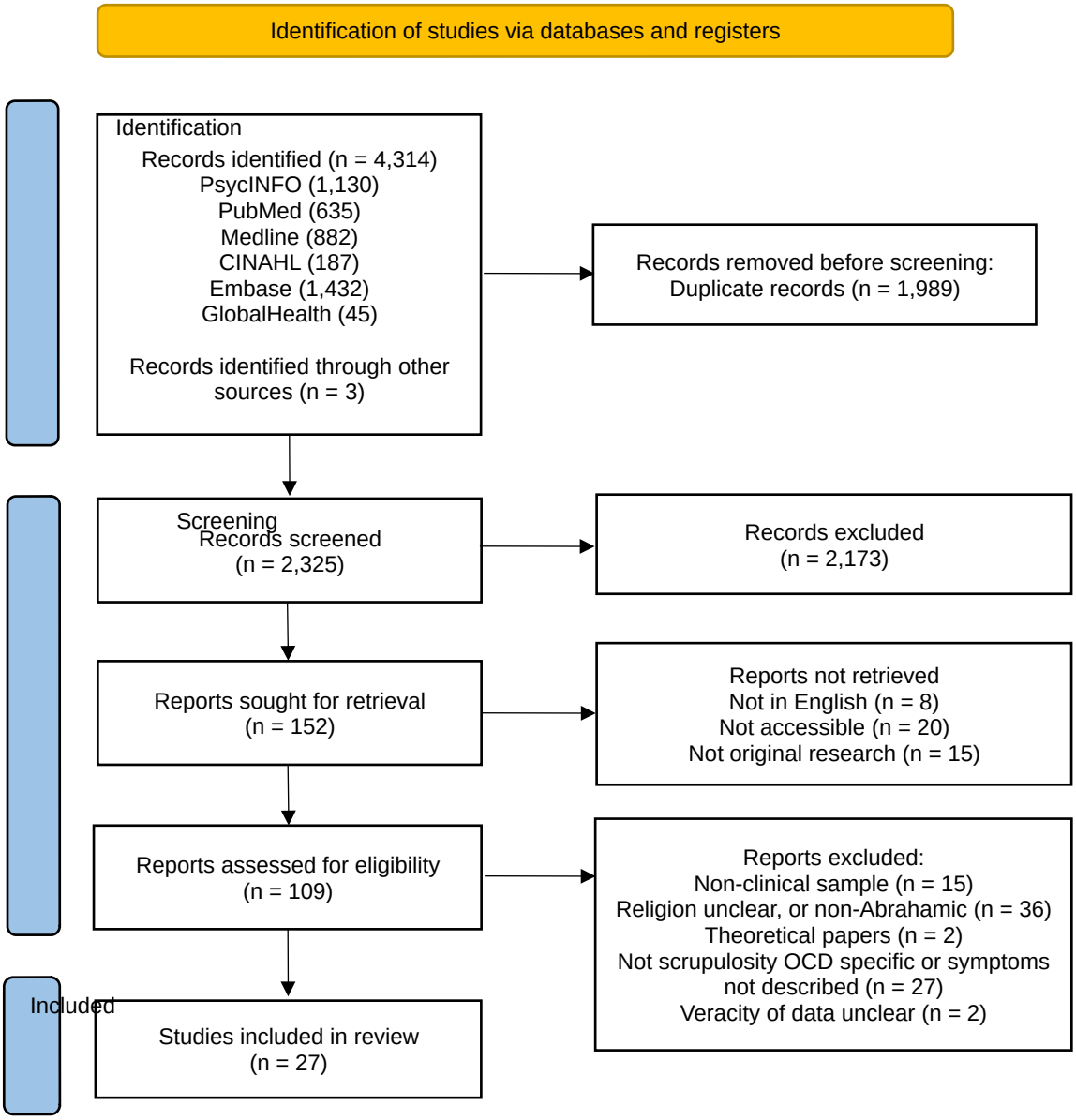
Selection Process

After running the initial search, 1,989 duplicate studies were eliminated, and 2,324 titles and abstracts were screened for possible inclusion. The second reviewer (MI) independently screened 20% at this stage, for which a Cohen's kappa of $\kappa = .86$ was achieved. One hundred and fifty-two full-text records were sought for retrieval, of which 109 were retrieved and screened. The second

reviewer then independently assessed 20% of the full texts, of which a Cohen's kappa of κ = .93 was achieved. Disagreements at both stages were resolved by discussion with the third author. Following this process, 27 articles were identified as eligible for inclusion. Figure 1 presents a PRISMA diagram following guidelines by Page et al. (2021) of this systematic search process.

Figure 1

PRISMA Diagram Summarising the Results of the Systematic Search



Excluded Studies

Studies that appear to meet the inclusion criteria but were excluded include a case description by Awana and Jena (2002) who reported on a Muslim female with sexual, but not religious, obsessive thoughts; a case report by Gangdev (1998) who described a client who had 'turned away from Christ', therefore making the current faith belief unclear; and Huppert and Siev (2010) who described a case which is a hybrid of actual clients seen. Two studies conducted in Pakistan were excluded due to the veracity of the data being under question (Nazar & Shafique, 1999; Nazar et al., 2011). Two almost identical papers by Rassool (2019, 2020) were found in two different journals, the first of these was included in this review as there was no reason to question the veracity of the case reported.

Quality Assessment

Given the variety of study designs included, risk of bias was assessed using three different tools (Appendix C). The Standard Quality Assessment Criteria for Evaluating Primary Research Papers (Kmet et al., 2004) was used for prevalence and cross-sectional studies, The Joanna Briggs Institute Critical Appraisal Checklist for Case Reports (The Joanna Briggs Institute, 2017) was used for case reports, and those relying on qualitative methods of data collection (e.g. interviews) were assessed using the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (The Joanna Briggs Institute, 2020).

Items on the checklists were rated on a 3-point scale (0 = no, 1 = partial, 2 = yes), and overall quality scores were calculated by dividing the total sum of scores by the total possible sum. Studies were rated as 'low quality' if they scored below 50%, 'fair quality' if they scored between 50-65%, 'good quality' if they scored between 66-80%, and 'high quality' if they scored above 80%. Thirty percent of papers were independently quality

assessed by a second reviewer (MI), and there was almost perfect agreement between the two reviewers. Due to the use of different tools, risk of bias was not compared across study designs. Scores are reported in Table 3 and Table 4 below.

The overall quality of prevalence and cross-sectional design studies was good. Three papers scored >80% (high quality), and four papers scored between 75–80% (good quality). Predominant issues included not providing enough information on method of subject selection (Buchholz et al., 2019; Okasha et al., 1994; Steketee et al., 1991), not using clinical outcome measures (Al-Sabaie et al., 1992; Ibn Auf & Osman, 2022), and not reporting results in sufficient detail (Ibn Auf & Osman, 2022; Okasha et al., 1994; Shooka et al., 1998).

Studies that had aspects of qualitative data collection were generally of lower quality, with four studies scoring between 35-45% (low quality), two papers scoring between 50-55% (fair quality), and the two most recent studies scoring between 70-75% (good quality). This may reflect increasing methodological rigour and development of standards for qualitative research. Although none of the included studies stated their philosophical perspective, there was general congruence between research methodology, objectives, and methods used to collect data: this was usually in the context of aiming to understand symptom presentation through interviews. However, a number of studies demonstrated a lack of congruity between methodology and representation and analysis of data: rich interview data were often reduced to frequencies, resulting in participants and their voices not being adequately represented. Only one study, Al-Solaim and Loewenthal (2011), which was rated as ‘good quality’ included a statement locating the researcher culturally and considered the influence of the researcher on the research and vice-versa.

There was also variability in the quality of case description studies; two studies scored >80%, (high quality), five papers scored between 69-75% (good quality), four papers scored between 63-50% (fair quality), and one paper scored 44% (low quality). Client demographics generally focused on age, gender, and religious affiliation, with key information on race and ethnicity not reported. Although clinical conditions were generally clearly described, the majority of studies did not include information about medical, family, and psychosocial history, and only four clearly described and presented the client's history as a timeline (Abramowitz, 2001; Burt & Rudolph, 2000; Garcia, 2008; Greenberg et al., 1987). The majority of case studies did not refer to diagnostic tests to confirm diagnosis, with only three providing sufficient information about how clients were assessed (Abramowitz, 2001; Garcia, 2008; Soltanmohammadlou et al., 2022). Interventions were generally well described; however, potential adverse events or harms were rarely considered, and post-intervention clinical condition descriptions were lacking in a number of studies (Bonchek & Greenberg, 2009; Burt & Rudolph, 2000; Fallon et al., 1990; Greenberg, 1984; Rassool, 2019; Soltanmohammadlou et al., 2022). Case reports generally summarised key lessons and provided practical clinical guidance.

Aspects of research design and integrity such as reporting on power and evidence of ethical approval, which have only become firmly embedded in more recent years, were lacking in this body of literature.

Data Extraction and Synthesis

Data were systematically extracted by the first author using an extraction sheet designed for this review which included authors; year of publication; location; religion; study design; sample size; key demographics; outcome and assessment measures; OCD symptomology; and treatment information. Missing or unclear information was not

recorded with the exception of religion which was recorded if it was made clear from details given in the results and discussion. It is of note that we have reported geographical location in a way that is in keeping with international law and political commitment to disrupting settler colonial logics (see Sheehi & Sheehi, 2020, 2021): Jerusalem and the state now known as Israel are therefore reported separately.

Data were synthesised using a narrative synthesis approach (Popay et al., 2006), which adopts a textual approach to 'tell the story' of the findings from included studies. This approach is suitable for a review which includes both quantitative and qualitative data and where inclusion criteria are broad and high heterogeneity was expected across studies.

Table 1 and Table 2 below summarise the design, aims, diagnostic criteria, clinical measures, method of data collection, and data analysis in the 27 included studies. Table 1 summarises prevalence, cross-sectional, and qualitative studies, and Table 2 summarises case description studies, including n = 1 studies. Data collection and data analysis refer to only the data which were extracted for the purpose of this review. Data irrelevant to this review may have been collected and analysed using other methods not reported here.

The characteristics and main findings of included studies are summarised in Table 3 and Table 4. Table 3 summarises prevalence, cross-sectional, and qualitative studies, and includes percentages of symptoms reported where these were given, and Table 4 summarises case studies, including n = 1 studies, which provide more detailed clinical information.

Table 1

Study Characteristics of Papers to be Synthesised: Quantitative and Qualitative Methodologies

Author, year	Design	Aims	Diagnostic Criteria	OCD Measures	Data Collection	Data Analysis
Mahgoub & Abdel-Hafeiz, 1991	Prevalence	To investigate the pattern of OCD in a Saudi culture and to ascertain the impact of religion on the phenomenology.	ICD-9	-	Semi-structured interviews	Frequencies
Steketee et al., 1991	Cross-sectional Analytical	To examine the relationships among types of religious practice and upbringing, degree of religiosity, type and severity of obsessive-compulsive symptoms, and guilt and depression in obsessive-compulsive and other anxiety disorders.	DSM-IIIR	YBOCS MOCI CAC	Cross-sectional. Interviews	Qualitative report
Al-Sabaie et al., 1992	Prevalence	To examine the phenomenology of Obsessive-Compulsive Disorder in the Moslem culture of Saudi Arabia.	DSM-IIIR	YBOCS	Review of medical notes	Frequencies
Okasha et al., 1994	Prevalence	To study the nature and severity of OCD symptoms in obsessive Egyptian clients and to determine the impact of culture on their symptomatology. To assess the comorbidity with OCD and to investigate the premorbid personality patterns prevailing in the studied sample.	ICD-10	YBOCS	Questionnaire	Frequencies
Eğrelimez et al., 1997	Prevalence	To investigate the most common obsession themes among Turkish OCD clients and to find out the reflections of religious beliefs on phenomenology.	DSM-IIIR	-	Structured clinical interviews	Frequencies, qualitative report
Shooka et al., 1998	Prevalence	To highlight the frequency with which the different forms and contents of OCD occur.	ICD-10	MOCI Global OC Scale	Structured clinical interviews	Frequencies
Greenberg & Shefler, 2002	Prevalence	To compare the experience of religious and non-religious symptoms of OCD in Ultra-Orthodox Jewish clients with OCD.	ICD-10	-	Semi-structured interviews	Content analysis

Karadaĝ et al., 2006	Prevalence	To investigate the clinical features of OCD and the possible association between obsessive–compulsive symptoms and culture-related characteristics in a sample of Turkish clients with OCD	DSM-IV	YBOCS	Structured clinical interviews	Frequencies
Saleem & Mahmood, 2009	Prevalence	To understand the phenomenon of OCD in Pakistani culture by exploring the presentation and manifestation of symptoms, comorbidity with anxiety and depression, and their relationship to demographic variables.	DSM-IV-TR	-	Semi-structured interviews, questionnaires	Frequencies
Jabeen & Kausar, 2010	Cross-sectional	To develop an indigenous scale for the assessment of OCD in Pakistan.	DSM-IV-TR	-	Semi-structured interviews, validity, factor structure	Frequencies
Al-Solaim & Loewenthal, 2011	Qualitative	To explore the role of religion in the experience of OCD among young, female, Saudi sufferers attending psychiatric clinics in Saudi Arabia.	-	-	Semi-structured interviews	Thematic Analysis
Mahintorabi et al., 2015	Cross-sectional Analytical	To examine relationships between religiosity, scrupulosity, cognitive beliefs and OCD among Muslim women with OCD washing subtype who presented for treatment in Tehran.	-	PIOS PI-WSUR	Questionnaires	Statistical Difference
Mahintorabi et al., 2017	Qualitative	To investigate the expression of OCD symptoms and help seeking for religious OCD symptoms among practicing Muslim women.	DSM-IV-TR	YBOCS	Semi-structured interviews	Thematic Analysis
Buchholz et al., 2019	Cross-sectional Analytical	To examine relationship between religious affiliation and OCD symptoms, religious affiliation and scrupulosity, and scrupulosity and OCD symptoms across religious affiliations.	-	PIOS YBOCS DOCS	Questionnaires	Statistical Difference
Ibn Auf & Osman, 2022	Prevalence	To explore the phenomenology of obsessive-compulsive disorder in a sample of Sudanese clients in relation to socio-demographic factors.	DSM-V	-	Review of medical notes	Frequencies

Note. YBOCS=Yale-Brown Obsessive Compulsive Symptom Checklist, MOCI=Maudsley Obsessional Compulsive Inventory, CAC=Compulsive Activity

Checklist, PI-WSUR=Padua Inventory-Washington State University Revision, DOCS=Dimensional Obsessive-Compulsive Scale

Table 2

Study Characteristics of Papers to be Synthesised: Case Studies

Author, year	Design	Aims	Diagnostic Criteria	OCD Measures	Intervention	Data Analysis
Greenberg, 1984	Case series description	Presents religious compulsions in four clients to show phenomenological similarities and differences between religious and compulsive rituals.	-	-	NA	NA
Greenberg et al., 1987	Case series description	Presents four cases to demonstrate variety of presentations, and to evaluate diagnostic issues.	-	-	NA	NA
Fallon et al., 1990	Case series Interventional	Report on use of the serotonin uptake blockers clomipramine and fluoxetine in the treatment of 10 clients with scrupulosity.	-	-	Pharmacotherapy	Qualitative report
Burt & Rudolph, 2000	Case study Interventional	Describes the complex issues involved in the treatment of comorbid OCD and major depression in an orthodox Jewish woman of childbearing age.	-	-	Pharmacotherapy and behavioural exposure therapy	Qualitative report
Abramowitz, 2001	Case study Interventional	The case history describes the successful use of Exposure and Response Prevention for a client with scrupulosity.	DSM-IV	YBOCS	ERP	Pre, mid, post treatment, follow up
Garcia, 2008	Case study Interventional	Describes the treatment of OCD and depression using CBT and psychodynamic therapy.	ICD-10	YBOCS	ERP and Psychodynamic therapy	Pre and post treatment scores
Vishne et al., 2008	Case series description	Presents three case reports related to the development of obsessive-compulsive symptoms in relation to the menstrual cycle among ultra-orthodox women, and discusses the biological and social-cultural basis of the disorder.	-	-	NA	NA

Bonchek & Greenberg, 2009	Case series Interventional	Presents a method of guided-prayer repetition, a variant of ERP, is described, and its successful application is reported in three cases of ultra-orthodox Jewish men with prayer as the main symptom of their religious OCD	-	-	Guided prayer repetition (ERP)	Qualitative report
Abouhendy & Jawad, 2013	Case series description	Discusses six case presentations of Arabic Muslim people suffering from OCD and closely associated religious rituals which tend to dominate the clinical picture.	-	-	NA	NA
Mohamad Arip et al., 2018	Case study Interventional	Reports a client with mental pollution OCD, who responded to Islamic Integrated Exposure Response Therapy.	DSM-V	YBOCS PIOS ROCSS	Islamic Integrated ERP	Pre and post treatment scores
Rassool, 2019	Case study Interventional	Examines the different types and sources of Waswâs al-Qahri and presents a case report with spiritual interventions.	DSM-V	-	Spiritual Interventions and Islamic Focused Centred Therapy	Qualitative report
Soltanmohammadlou et al., 2022	Case study Interventional	Examines effectiveness of online cognitive therapy in a Muslim client with scrupulosity employing in-vivo exposure.	DSM-V	YBOCS	ERP	Session-by-session scores with follow up

Note. ERP=Exposure and Response Prevention, ROCSS=Religious OC Symptoms Scale

Table 3

Study Characteristics and Findings of Papers to be Synthesised: Quantitative and Qualitative Methodologies

Author, year	Location	Religious Affiliation	Sample Gender	Age Mean Range	Themes of scrupulosity OCD symptoms		Quality Rating
					Obsessions	Compulsions	
Mahgoub & Abdel-Hafeiz, 1991	Saudi Arabia	Muslim	*n* = 32 18F, 14M	*M* = 26.6	Prayers and body washing (50%), contamination (41%), faith (34%)	Religious repeating (50%), washing (37%)	Low
Steketee et al., 1991	America	64% Catholic 12% Protestant 15% Jewish	*n* = 33 Unknown	*M* = 34.2	Blasphemous thoughts, prayers, washing rituals, sexual thoughts	Confessing sins, feeling contrition	Good
Al-Sabaie et al., 1992	Saudi Arabia	Muslim	*n* = 45 19F, 26M	*M* = 27.5 R = 15-61	Cleaning, washing	Prayers, ablution	High
Okasha et al., 1994	Egypt	90% Muslim 10% Christian	*n* = 90 28F, 62M	*M* = 23.7 R = 12-42	Religion (60%), contamination (60%)	Washing (63.33), ablution and ritualistic baths (67.78)	Good
					Rituals more frequent in Muslim than Christian participants		
Eğrelimez et al., 1997	Turkey	Muslim	*n* = 45 28F, 17M	*M* = 36.99	Blasphemous thoughts about God, washing before prayers	-	Fair
Shooka et al., 1998	Bahrain	Muslim	*n* = 50 37F, 13M	*M* = 30.4 R = 18-65	Blasphemous thoughts and doubts (40%)	Washing	Good
Greenberg & Shefler, 2002	Israel*	Jewish	*n* = 28 7F, 21M	R = 17-43,	Cleanliness before prayer, inadequate concentration (52%), post-menstrual purity (10%), dietary laws (18%), Passover home (14%)	Washing before prayer (36%), repeating prayers (52%), post-menstrual checking (86%)	Low

Karadaĝ et al., 2006	Turkey	Muslim	*n* = 141 99F, 41M	*M* = 30.53 R = 16-73	Prayer, ablution, ritualistic bath (50%)	Repeating rituals (83%) washing, ritualistic bath	Low
					Sexual obsessions linked with religious obsessions		
Saleem & Mahmood, 2009	Pakistan	Muslim	*n* = 113 46F, 67M	R = 16-50	"Napak" (67.26%), negative thoughts about God and religion (65.49%)	-	Fair
Jabeen & Kausar, 2010	Pakistan	Muslim	*n* = 200 106F, 94M	*M* = 30	"Napak", cleanliness, impurity in food, blasphemous thoughts	Repeating the Quran and the 'Qalima', control of attention	Low
Al-Solaim & Loewenthal, 2011	Saudi Arabia	Muslim	*n* = 15 16F, 18M	R = 14-30	Prayers, ablution (100%), thoughts about faith, the prophet, and God's creation (20%)	Repeating prayers, excessive washing for ablution.	Good
Mahintorabi et al., 2015	Iran	Muslim	*n* = 15 15F	R = 24-75	-	Washing rituals.	Good
Mahintorabi et al., 2017	Australia**	Muslim	*n* = 5 5F	*M* = 39 R = 33-45	Prayers, purity after menstruation, fear of sin, acceptance of rituals.	Repeated ablution, ritualistic baths, repeating prayer	High
Buchholz et al., 2019	America	37.2% Catholic 26.7% Protestant 10.6% Jewish	*n* = 180 76F, 104M	*M* = 30.3 R = 16-68	In Protestant and Catholic participants, scrupulosity and unacceptable thoughts were correlated. In Catholic participants, scrupulosity correlated with responsibility for harm. In Jewish participants, scrupulosity was correlated with unacceptable thoughts, responsibility for harm, and contamination.		High
Ibn Auf & Osman, 2022	Sudan	Muslim	*n* = 89 34F, 55M	*M* = 27.12	Presence of God, being Muslim or not (34.8%) contamination (24.7%)	Washing (37.1%)	Good

Note. F=Female, M=Male, SS Interview = Semi-Structured Interview, SC Interview = Structured Clinical Interview
Note. 'low quality' <50%, 'fair quality' = 50-65%, 'good quality' = 66-80%, 'high quality' >80%.
*16 were Israeli-born, 11 from the US and UK, 1 from Belgium.
**Participants had immigrated to Australia from Iran, Iraq, Turkey, and Afghanistan

Table 4

Study Characteristics and Findings of Papers to be Synthesised: Case Studies

Author, year	Location	Religious Affiliation	Gender Age	Themes of scrupulosity OCD symptoms		Quality Rating
				Obsessions	Compulsions	
Greenberg, 1984	Jerusalem	Jewish	M 35	Meat coming into contact with milk	Decontaminating family and utensils	Poor
			M 25	Bread in the Passover home, meat and milk coming in contact, saying prayers properly	Cleaning before Passover, cleaning of kitchen items, handwashing, repeating prayers	
			M 26	Completeness of faith in prayer, sexual thoughts, cleanliness before prayer	Excessive time in prayer and preparation for prayer, checking and cleaning of orifices	
			F 60	Blasphemous thoughts, fear of contaminating artifacts and clothes	Repeating statements of forgiveness, handwashing	
Greenberg et al., 1987	Jerusalem	Jewish	M 33	Validity of marriage ceremony, wife's menstrual cleanliness	Reassurance seeking, excessive time spent on important portion of prayers	Good
			M 19	Forgetting parts of the prayer, praying improperly, handwashing	Praying slowly and repeating, handwashing	
			M 31	Rectal impurity	Repeating sections of prayer, cleaning self, checking for impurity in the home	
Fallon et al., 1990	America	Christian	M 69	Morality of actions	Repeated confessions	Fair
		Catholic	F 67	Sexual thoughts	Excessive praying, repeated confession, mass attendance	
		Jewish	M 29	Tax returns and marital vows	Reporting self to ethics committee	
		Jewish Orthodox	F 21	Sexual thoughts	Avoiding white matter that symbolises semen	
		Catholic	M 32	Guilt about sex	Repeated confessions	
		Jewish	M 26	Sexual emissions	Excessive washing	

		Jewish Orthodox	F 32	Contamination and 'proper' rituals	Excessive washing	
		Catholic	M 53	Immorality, blasphemous thoughts	Excessive washing	
Burt & Rudolph, 2000	America	Jewish	F 26	Contaminating food/utensils, post-menstrual purity, cheating cashiers when paying	Washing contaminated food, checking kosher labels, repeated immersions, checking menstrual flow	Fair
Abramowitz, 2001	America	Catholic	M 36	Being immoral, not being forgiven, inadvertently 'corrupting' others	Mentally reviewing conversations and activities, reassurance seeking	High
Garcia, 2008	America	Catholic	F 21	Being selfish or morally reproachable, causing harm to others	Praying, crossing, kneeling, looking up to the sky towards God	High
Vishne et al., 2008	Israel	Jewish Ultra Orthodox	F 42	Post-menstrual purity	Repeated checking, reassurance seeking	Fair
			F 40	Post-menstrual purity	Repeated checking, reassurance seeking	
			F 26	Post-menstrual purity, payment after shopping	Repeated checking, repeated counting of seven days checking payment	
Bonchek & Greenberg, 2009	Jerusalem	Jewish Ultra Orthodox	M 18	Not described	Repetition and pauses in prayers, praying loudly, handwashing	Fair
			M 24	Not described	Repetition in prayers	
			M 20	Not described	Ablution, excessive cleaning, repetition when reciting Torah and when praying	
Abouhendy & Jawad, 2013	Middle East	Muslim	M 21	Anal and penile sensation of passing fluid	Excessive time in the toilet, ablution, prayers	Good
			M 25	Not described	Ablution	
			F 22	Not described	Not described	
			M 29	Blasphemous thoughts and hearing the devil during prayers	Not described	
			M 23	Blasphemous images while praying	Not described	
			F 26	Abnormal vaginal sensations during prayer, interfering with ablution	Not described	

Mohamad Arip et al., 2018	Malaysia	Muslim	F 27	Impurity impacting acceptance of prayers, proper recitation of prayer	Washing, cleaning, showering, repeating ablution, and recitation during prayer	Good
Rassool, 2019	Unknown	Muslim	F 26	Contamination of clothing, improper ablution, recitation/motion of prayer	Excessive washing of clothes and body, changing into ‘clean’ clothes, ablution	Fair
Soltanmohammadlou et al., 2022	Iran	Muslim	F 37	Impurity impacting acceptance of prayers, ablutions	Pure/impure separation, hand washing, repeating ablution, reassurance seeking	Fair

Results

Research Aims and Design

As seen in Table 1, nine studies used a cross-sectional prevalence design, three used a cross-sectional analytical design, and two used a qualitative design. As seen in Table 2, eight studies were interventional: six studies used an interventional case study design, and two used an interventional case series design. Four used a case series description design.

The majority of studies aimed to describe the nature of OCD symptoms in their samples. One study aimed to design a scale and undertook steps to generate symptoms, examine validity and factor-structure (Jabeen & Kausar, 2010).

Diagnostic Criteria and Measures

Fifteen studies out of the 27 stated which diagnostic criteria were used to assess OCD. Of these, three used the Diagnostic and Statistical Manual of Mental Disorders-III-R, three used the Diagnostic and Statistical Manual of Mental Disorders-IV, three used the Diagnostic and Statistical Manual of Mental Disorders-IV-TR, two used the Diagnostic and Statistical Manual of Mental Disorders-V, one used the International Classification of Diseases-9, and three used the International Classification of Diseases-10.

Clinical measures of OCD were mentioned in 12 of 27 studies, with the Yale-Brown Obsessive Compulsive Symptom Checklist (Goodman et al., 1989) mentioned in 11 studies, the Penn Inventory of Scrupulosity (PIOS; Abramowitz et al., 2002) mentioned in three studies, the Maudsley Obsessional-Compulsive Inventory (Hodgson & Rachman, 1977) mentioned in two studies, and the following used once each: the Padua Inventory–Washington State University Revision (Burns et al., 1996), the Dimensional Obsessive-Compulsive Scale (Abramowitz et al., 2010), the Global Obsessive Compulsive Scale

(cited in Goodman et al., 1989), the Obsessional Beliefs Questionnaire 44 (OCCWG, 2005), the Religious OC Symptoms scale (Asif, 2015), and the Compulsive Activity Checklist (Freund et al., 1987).

Data Collection and Analysis

As shown in Table 1, methods of data collection varied. The majority of studies adopted an interview approach, with three studies utilising questionnaires only, and two studies conducting reviews of medical notes of participants.

The majority of studies presented information on symptom presentation in the form of frequencies. In a number of studies, frequency data were supplemented with further qualitative information detailing the content of symptoms either in the results section on in discussion sections of papers. One study presented a content analysis (although the authors did not describe it as such), and two studies with qualitative designs conducted thematic analyses.

Of the eight interventional studies presented in Table 2, only four reported changes in clinical measures, although Garcia (2008) did not report measures following phase-2 of the treatment provided to their client. Baseline measures were reported in two studies (Mohamad Arip et al., 2018; Soltanmohammadlou et al., 2022), although Mohamad Arip et al. (2018) did not report the number of baseline measures taken. Follow-up measures were reported in two studies (Abramowitz, 2001; Soltanmohammadlou et al., 2022). The remaining four interventional studies provided qualitative descriptions of post-treatment conditions.

Sample

As seen in Table 3, 15 studies which used quantitative or qualitative methodologies met the inclusion criteria. These comprised a total of 1,032 participants (data for religious versus non-religious participants were separated in Buchholz et al. 2019; Steketee et al. 1991). One study reported on participants with the same subtype of OCD (washing subtype; Mahintorabi et al., 2015). The majority of these studies reported on Muslim participants.

The average age of clients reported was 29.56 years, with a range of 12-75 years. Data from individuals under the age of 18 reported in case studies or qualitative studies have not been included in this review. It was not possible to separate the data of those under 18 for prevalence and cross-sectional studies, and they have therefore been included in the analysis as the mean ages of these samples indicates that the majority of participants were over 18 years of age.

As seen in Table 4, 12 case studies met the inclusion criteria, and reported on a total of 33 cases (19 males, 14 females). The mean age of participants was 31.73 years (range = 18-69). Six studies reported on single cases (Abramowitz, 2001; Burt & Rudolph, 2000; Garcia, 2008; Mohamad Arip et al., 2018; Rassool, 2019; Soltanmohammadlou et al., 2022) and two studies reported on three clients each with the same focus of symptoms (Bonchek & Greenberg, 2009; Vishne et al., 2008). A total of 18 Jewish clients, nine Muslim clients, and six Christian clients were described.

Key Findings

Christians

Of the six studies on Christian participants, the most common themes were confessing sins and feeling contrition (mentioned in four studies: Abramowitz, 2001;

Fallon et al., 1990; Garcia, 2008; Steketee et al., 1991); obsessions related to unacceptable thoughts or behaviour (mentioned in five studies: Abramowitz, 2001; Buchholz et al., 2019; Fallon et al., 1990; Garcia, 2008; Steketee et al., 1991); and a sense of responsibility for corrupting or harming others (mentioned in three studies: Abramowitz, 2001; Buchholz et al., 2019; Garcia, 2008).

Given the lack of strict behavioural codes in Christianity as compared to Islam and Judaism, this may explain why symptoms were less ritual-driven. In line with this, Buchholz et al. (2019) found that in Protestant and Catholic participants, there was a significant correlation between scrupulosity and a measure of unacceptable thoughts. The association between thoughts and actions in Christianity, whereby thoughts of committing sin can be seen as equal to committing the sin itself (Cohen & Rozin, 2001), may explain the findings in this review of participants being overly conscious of and trying to control thoughts they viewed as immoral. These included unacceptable sexual thoughts such as images of the devil assaulting the Virgin Mary (Steketee et al., 1991), as well as blasphemous thoughts (Fallon et al., 1990).

Christian participants also described inflated responsibility for failing to prevent sin in others, inadvertently ‘corrupting’ others, or causing others misfortune. In Buchholz et al.’s (2019) study, responsibility for harm was correlated with level of scrupulosity in Catholic participants specifically. This idea was supported by two high quality case studies: Garcia (2008) describes a client who compulsively crossed herself and prayed whenever she heard an ambulance siren because she felt responsible for the wellbeing of the patient in the ambulance, and Abramowitz (2001) describes a client who worried that if he did not set a moral example at all times, he would “corrupt” others, and as a result,

avoided social engagement and compulsively mentally reviewed all his conversations and activities.

The Catholic custom of alleviating guilt through prayer and confession (Murray-Swank et al., 2007) was also a key theme in this literature. In a case series description of fair quality, Fallon et al. (1990) report on three participants excessively confessing sins multiple times a week and attending mass multiple times a day. In Garcia's (2008) case study, the client compulsively prayed in order to feel contrition, and excessive confessing of sins is noted also in Steketee et al. (1991).

Jews

Of the nine studies including Jewish participants, there was an overarching focus on behavioural codes around purity, prayer, and dietary laws. Symptoms related to prayer were mentioned in five studies (Bonchek & Greenberg, 2009; Greenberg, 1984; Greenberg & Shefler, 2002; Greenberg et al., 1987; Steketee et al., 1991), laws concerning family-purity mentioned in four studies (Burt & Rudolph, 2000; Greenberg & Shefler, 2002; Greenberg et al., 1987; Vishne et al., 2008), kosher food laws in three studies (Burt & Rudolph, 2000; Greenberg, 1984; Greenberg & Shefler, 2002), and general immoral behaviour mentioned in three studies (Fallon et al., 1990; Burt & Rudolph, 2000; Vishne et al., 2008. The relationship between scrupulosity and a measure of contamination in Buchholz et al. (2019) is consistent with the emphasis on purity.

Jews recite the 'Amidah', a prayer which is the core of every Jewish worship service, repeated three times every day. The 'Shema', recited typically in the morning and evening and before sleep, is an affirmation of Judaism and declaration of faith in one God, and requires greater concentration than the rest of the prayer. Bonchek and Greenberg (2009) described compulsive repeating of the Shema, with one client repeating it 190

times, and Greenberg (1984) described a client who spent over three hours daily in prayer due to pauses and repetition because of doubt in the completeness of his faith while praying. In both Greenberg (1984) and Greenberg and Shefler (2002), cases are described of intrusive sexual thoughts during important parts of the prayer.

Also mentioned in three case description studies (Fallon et al., 1990; Greenberg, 1984; Greenberg & Shefler, 2002) were obsessions around cleanliness before prayer such as rectal impurity, and fears of contaminating religious artefacts (such as candlesticks), with compulsive wiping and washing. Excessive handwashing was also reported, linked to the tradition of ritualised hand washing and saying a blessing before eating meals that include bread (Greenberg, 1984; Greenberg & Shefler, 2002).

Dietary laws (‘Kashrut’) were mentioned in case studies in relation to fears of contaminating food and utensils with non-Kosher food, and meat coming into contact with milk (Greenberg, 1984), resulting in a client skipping meals (Burt & Rudolph, 2000). Related compulsions including extensive efforts to decontaminate, including cleaning utensils, draining board, food items, and individuals.

Family-purity laws were a theme of obsessions in both Jewish men (for their wives), and in women (Burt & Rudolph, 2000; Greenberg et al., 1987; Vishne et al., 2008). In Judaism, menstruating women practice the laws of ‘Niddah’, where a husband and wife separate physically for 7 consecutive days following the ending of her menstrual cycle. During this time, women must check with linen (once in the morning and once before sunset) to find any trace of blood, and if so, begin counting the seven days again. After this, women immerse in a ‘Mikva’ (a ritual bath), to become pure again. Vishne et al. (2008) described a client repeatedly checking for blood with linen for hours a day resulting in wounds, with one client requesting that her uterus be removed to end her doubt. Another

client in their study re-started counting the seven-day period repeatedly due to doubt and did not immerse herself, or have sexual relations with her husband for months. In the case presented by Burt and Rudolph (2000), the client sought reassurance from her rabbi who would examine her linen monthly.

Muslims

Of the 16 studies on Muslim participants, the predominant theme was prayer, referenced in all studies, but not explicitly mentioned in the results section of two studies (Ibn Auf & Osman, 2022; Shooka et al., 1998), and washing and ritual purity in preparation for prayer were mentioned in all studies. Blasphemous or negative thoughts about faith were mentioned in nine studies (Abouhendy & Jawad, 2013; Al-Solaim & Lowenthal, 2011; Eğrelimez et al., 1997; Ibn Auf & Osman, 2022; Mahgoub & Abdel-Hafeiz, 1991; Mahintorabi et al., 2017; Jabeen & Kausar, 2010; Saleem & Mahmood, 2009; Shooka et al., 1998). These findings suggest the relevance of both practice and correct belief in Muslims with scrupulosity.

Prayer (‘Salah’) is a central pillar of the Islamic faith; Muslims pray five times a day at specified times. Prayers are composed of set phrases and movements including bowing and prostrating, and recitation of the Quran. Obsessions related to performing prayers “just right”, including the physical motions and recitation (Mohamad Arip et al., 2018; Rassool, 2019), and fears of prayers not being accepted (Al-Sabaie et al., 1992; Al-Solaim & Loewenthal, 2011; Karadaĝ et al., 2006; Mahgoub & Abdel-Hafeiz, 1991; Mahintorabi et al., 2017). Compulsions included repeating prayers and reassurance seeking by asking family to observe the act of praying (Mahintorabi et al., 2017; Al-Solaim & Loewenthal, 2011).

A condition of Islamic prayer is ‘Taharah’, which refers to both physical cleanliness as well as spiritual purification. Muslims must be physically clean as well as engage in either a major ablution (‘Ghusl’) or a minor ablution (‘Wudu’) in order to pray. Wudu entails washing parts of the body including the face, arms, and wiping over the head and feet. Ghusl is for the removal of major ritual impurities (such as sexual discharge, menstruation, and postpartum bleeding), and entails washing the entire body. Obsessive thoughts included being contaminated by splashes of water from the toilet (Mohamad Arip et al., 2018; Rassool, 2019), sensations of discharge which would invalidate ablution (Abouhendy & Jawad, 2013), and improper ghusl (Karadaĝ et al., 2006; Mahintorabi et al., 2017; Okasha et al., 1994). In both Pakistan-based studies, participants used the term “napak”, to describe a feeling of contamination “with strong religious connotations of dirtiness or unholiness”. In the case presented by Soltanmohammadlou et al. (2022), the client divided her house into ‘pure’ and ‘impure’ sections, and in Rassool (2019), the client would change into ‘clean’ clothing seven or more times a day.

Blasphemous thoughts and images including about God, the prophets, and Satan were mentioned in a number of studies (Eğrelimez et al., 1997; Ibn Auf & Osman, 2022; Jabeen & Kausar, 2010; Saleem & Mahmood, 2009; Shooka et al., 1998), however, these obsessions were not described in detail. In a ‘good’ quality qualitative study, Al-Solaim and Loewenthal (2011) noted that thoughts about God and the beginning of creation were relatively rare. Both Mohamad Arip et al. (2018) and Rassool (2019) use the term ‘Waswas’, to conceptualise intrusive thoughts through an Islamic framework; Waswas are understood as unwanted thoughts which are the whisperings of the devil. Compulsive acts included repeating verses of the Quran and repeating a statement of the oneness of God (Jabeen & Kausar, 2010; Saleem & Mahmood, 2009). Highly religious participants in Mahintorabi et al. (2015) had higher scores on measures of importance and control of

thoughts suggesting that there may be a relationship between level of religiosity and this symptom presentation.

Clinical Implications

The papers reviewed in this study suggest that building rapport and trust as an 'outsider' to a client's faith may be challenging, especially given findings of associated shame and stigma resulting in therapy being sought as a last resort (e.g. Al-Solaim & Loewenthal, 2011; Mahintorabi et al., 2017). These findings draw attention to cultural and faith understandings of the origins of symptoms such as 'evil-eye' (Al-Solaim & Loewenthal, 2011), terminology such as 'waswas' (Mohamad Arip et al., 2018; Rassool, 2019), 'napak' (Jabeen & Kausar, 2010; Saleem & Mahmood, 2009), as well as the need to work within a client's value system by integrating religious parables and guidelines into therapy (Abramowitz, 2001; Mohamad Arip et al., 2018).

In assessing for symptoms related to contamination in Jewish and Muslim clients, papers reviewed showed that it is important to understand whether a washing ritual is being conducted for physical cleanliness, spiritual purity, or both. This is illustrated by Mohamad Arip et al.'s (2018) case description in which the client superficially appeared to have a typical fear of contamination with compulsive washing, but her obsessions were mainly associated with a sense of religious impurity. Similarly, Jabeen and Kausar (2010) found that contamination related symptoms emerged as two separate subscales in their Muslim sample: filth (purity) related, and health related. In Christian clients, more attention may be paid to obsessions regarding inflated responsibility for committing or failing to prevent sin, as well as the importance of thought control. Religious obsessions may be closely linked to sexual obsessions in all groups (Fallon et al., 1990; Greenberg, 1984; Greenberg et al., 1987; Karadaĝ et al., 2006).

The papers reviewed also draw attention to factors which may have preceded the onset of symptoms such as following the assumptions of religious duties at puberty, changes of level of religiosity, or responsibility. In this review, examples included becoming engaged (Rassool, 2019), getting married (Greenberg et al., 1987), the death of a parent (Garcia, 2008; Greenberg et al., 1987), following a bar mitzva (Greenberg et al., 1987), and becoming more religious (Greenberg, 1984). Clinicians may find assessing these factors useful in developing longitudinal formulations.

Case studies in this review have described the use of gentle Socratic questioning to help clients to see that their urges to perform compulsive religious behaviours are motivated by fear, as opposed to faith, and are therefore maladaptive. Soltanmohammadlou et al. (2022) describe this as clients following their own rules by performing rigid acts, as compared to the way set out in their faith, which is to submit to God's word. Once a clear goal for treatment has been established, i.e. to help the client practice their religion as it was intended, the rationale for Exposure and Response Prevention (ERP) may be better understood (Abramowitz, 2001).

ERP may seem insensitive to religious values, and clients with scrupulosity may have difficulty directly confronting that which is perceived to be sinful. It is important that the hierarchy is co-constructed, and clinicians are aware of the risk of drop-out, as mentioned in Bonchek and Greenberg (2009) and Mahintorabi et al. (2017). Clinicians should also be aware of safety behaviours, such as engaging in private prayer before engaging in exposure to seek forgiveness (e.g. in Abramowitz, 2001).

Given the findings in this review of clients seeking advice from religious leaders, it may be beneficial to include religious leaders in developing treatment plans. This may help clinicians understand the limits of religiously acceptable behaviour, and create situations in

which ‘OCD law’ can be challenged without violating religious law. For example, in Bonchek and Greenberg’s (2009) case, the client sought approval from a Rabbi to repeat the name of God (which is forbidden if “in vain”) for the purposes of treatment. The case study by Abramowitz (2001) exemplifies how clinicians and religious authority may work together to target reassurance seeking specifically, whereby when reassurance is sought from clergy, clients are referred back to the therapist, or an agreement is reached in which clients will not seek reassurance from religious authorities while seeking treatment.

Discussion

This systematic literature review aimed to synthesise and assess the quality of research on scrupulosity OCD in Christian, Jewish, and Muslim clients. We also present the clinical relevance of these findings. The results are consistent with suggestions that theological differences between the Abrahamic faiths are reflected in symptom presentation of OCD (Huppert et al., 2007; Inozu et al., 2012). Christianity emphasises intentions, and faith is defined by belief rather than behavioural rituals, many Jewish commandments are practical in nature, whereas in Islam, there is a strong emphasis on correct practice combined with correct belief. These differences align with findings in this review. There was a focus on the importance of ‘correct’ thoughts and intentions in Christian participants, a focus on behavioural rituals in Jewish participants, and a predominant focus on behavioural rituals in Muslim participants combined with obsessional thoughts about faith.

Overall, the quality of the studies in this review was variable. Although studies with larger samples provided information about the prevalence of symptoms, these were largely poorly reported and lacked the richness of information provided by case studies. However, case studies did not present enough collateral information and were lacking in

the use of validated measures and diagnostic tests. It is notable that a number of case studies presented cases to illustrate treatment guidance, or conceptual integration of religious values into secular models of treatment. Overall, this body of literature would benefit from controlled studies with robust pre and post treatment measurement, as well as more consideration given to issues of ethical approval and consent.

Research on community samples finds similar patterns of symptom presentation: obsessionality shows a stronger relationship with scrupulosity symptoms in Christians than Muslims (Inozu et al., 2012), religiosity and moral thought-action fusion are not correlated in Jews (Siev et al., 2010; Siev & Cohen, 2007), and in Muslims the relationship is small to moderate (Yorulmaz et al., 2009). In community samples, compulsions in Muslim participants are more focussed on behavioural rituals than Christian participants (Kahya et al., 2023) and studies on community attitudes towards scrupulosity in Orthodox Jews use vignettes relating to specific behavioural rituals (e.g. Pirutinsky et al., 2009).

Implications

The clinical implications of this review underscore the need for clinicians to familiarise themselves with salient religious beliefs and rituals and work within clients' value systems. Clinicians should not only be comfortable to discuss and explore religious issues, but must also actively address gaps in their own knowledge in order to assess what is normative and what is not. Given diverse religious beliefs and practices within any religious groups, clinicians must be mindful of individual differences when assessing and treating scrupulosity OCD. Treatment guidance provided by Huppert and Siev (2010) and Abramowitz and Jacoby (2014) are valuable resources here.

This review also has implications for the measurement of scrupulosity. Currently, the only psychometrically validated measure of scrupulosity is the Penn Inventory of Scrupulosity (PIOS; Abramowitz et al., 2002), on which Christians tend to score higher (e.g. Abramowitz et al., 2002; Nelson et al., 2006), suggesting that the scale measures scrupulosity symptoms which are more likely to manifest in Christian samples (Huppert & Fradkin, 2016). Greenberg and Huppert (2010) suggest that the PIOS is a less sensitive measure of scrupulosity among Jewish individuals, although a later study with a small clinical sample found it to be a valid measure in Orthodox but not non-Orthodox Jews (Pirutinsky & Rosmarin, 2018). The PIOS has not been validated in a Muslim sample and it may be speculated, given the similarity in presentation to Judaism, that the PIOS may not be sensitive for scrupulosity in highly religious Muslims. Exploration of whether the PIOS captures the religious nuance in Islam is needed.

Future Research

Future research may also wish to explore the difference in symptom presentation between men and women. Washing rituals in Judaism and Islam are often related to menstruation and therefore women may also score higher on measures of contamination. Furthermore, although this review reports on differences between Orthodox and Ultra-Orthodox Jewish participants, the differences between these understandings of Judaism have not been considered in the analysis. Finally, given mention of reassurance-seeking from religious authorities throughout this body of literature, further research into their experiences and understanding of scrupulosity is warranted.

Limitations

Firstly, restricting eligibility to studies in English means that literature in other languages which may provide insight into differing cultural understandings of OCD are missed. Furthermore, due to the nature of the studies, it was not possible to limit inclusion criteria to studies with clear diagnostic procedure for OCD. The clinical judgement of the authors, comprising two trainee clinical psychologists and an experienced qualified clinical psychologist was used to determine suitability. Furthermore, given the variability in study designs, three different quality assessment tools were used to assess bias. Although this allows for thorough assessment depending on design, comparing quality across study designs was not done systematically and the assessment tools were instead used to guide the critical appraisal. Finally, while the inclusion of case studies was necessary in this review due to the dearth of literature, they lack generalisability and are subject to bias. Nevertheless, the similarities in both descriptive characteristics and main findings in terms of content of symptoms of participants in larger studies and case description studies suggests that clients presented in case studies may be representative.

Conclusion

In conclusion, this review provides a detailed outlook on the contents of obsessions and compulsions in Christians, Jews, and Muslims, and in doing so, highlights the differences in symptom presentation. For successful engagement and treatment of scrupulosity OCD, an approach in which research is combined with an understanding of salient religious beliefs and practices is needed. Clinicians working with religious clients should aim to familiarise themselves with normative practice to assess and treat that which has become pathological, and to support clients to return to seeking comfort and fulfilment through their faith.

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Service Improvement Project

Ethnic Minority Fathers' Experiences of the Neonatal Care Unit: A Qualitative Exploration of Barriers to Accessing Psychological Support

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Abstract

Background: The Neonatal Care Unit is a challenging environment for parents. Previous literature documents the need for increased and more specialised understanding of support for fathers. There remains a dearth of literature on the experiences of ethnic minority fathers in particular, who may be less likely to access psychological support available.

Method: This project aimed to understand the barriers ethnic minority fathers faced when accessing psychology support at a Neonatal Care Unit in England. Seven fathers from ethnic minority backgrounds participated in semi-structured interviews after their babies were discharged.

Results: Data were analysed using a Reflexive Thematic Analysis approach. Three main themes were identified: '*Psychology is a Threat*', '*It's Not Really Talked About in our Culture'*, and '*A Space for Mum, Not Me'*. These themes are discussed in reference to the extant literature, and recommendations are provided to improve access to support.

Conclusions: There is a need to recognise interacting influences of gender and cultural norms in supporting these fathers, including understanding the role of psychology, consideration of stigma, and knowing families in relation to their cultural context.

Keywords: Neonatal Care Unit, Psychology, Ethnic minority, Father, Help-seeking

Background

There is an increased focus on family-centred care in Neonatal Services in the United Kingdom, including in the National Health Service Long Term Plan (NHS, 2019), in consequent recommendations such as the Neonatal Critical Care Review (NHS Improvement, 2019), and most recently in the Getting It Right First Time (GIRFT, 2022) Neonatology Programme National Speciality Report. When parents play an active and substantive role in their baby's care, there are numerous positive outcomes, including in family cohesion and attachment (Flacking et al., 2012), better parental mental health (O'Brien et al., 2018), and lower infant readmission rates (Ding et al., 2019).

Parents require adequate support to play this active role on the Neonatal Care Unit (NCU), an environment fraught with stressors, which include medical procedures on fragile preterm babies, parent new-born separation, noisy and bright wards, as well as complex conversations with multiple professionals (Busse et al., 2013; Grosik et al., 2013; Mäkelä et al., 2018). Missing from our understanding of how to support parents is the paternal experience. A recent meta-analysis on parental stress interventions found many studies failed to report father-specific outcomes, and only 3 of 36 studies enrolled fathers alone (Sabnis et al., 2019). This finding is replicated in a systematic review in which fathers are underrepresented, comprising only 38% of the sample (Loewenstein et al., 2019).

This lack of research on how to support fathers is concerning given findings that 10% of fathers experience Paternal Perinatal Depression (PPD; Paulson & Bazemore, 2010), with figures rising to 30-40% when infants are in hospital (Cyr-Alves et al., 2018; Kong et al., 2013). Although for some fathers, symptoms of anxiety and depression

diminish over time (Cajiao-Nieto et al., 2021), PPD has significant long-term consequences on children, including internalizing and externalising behaviours in later childhood (Low et al., 2022). The emerging evidence base of qualitative studies (see Provenzi & Santoro, 2015) documents numerous vulnerability factors for fathers including the impact of traumatic births, simultaneously taking on more responsibility when mothers are physically unable to participate in care (Hagen et al., 2016), and also feeling a sense of a lack of control (Arockiasamy et al., 2008).

Crucially, fathers report a lack of adequate support as well as a lack of essential information regarding the care of their baby (e.g. Garten et al., 2013; Merritt et al., 2022; Sloan et al., 2008; Thomson-Salo et al., 2017). In the NCU environment, the focus of healthcare professionals' attention is on "mum and baby" (Govindaswamy et al., 2020), leaving fathers unable to share emotional difficulties, and without much-needed support (Coppola et al., 2013; Hugill et al., 2013; Pohlman, 2005).

Experiences of Ethnic Minority Fathers

The inclusion of minority groups in the literature on the paternal NCU experience is significantly lacking; the need for research that represents the diversity of racial and ethnic groups of families accessing Neonatal Care Units is underscored in a review of NCU parental mental health (Roque et al., 2017).

Theories such as Ajzen's Theory of Planned Behaviour (TPB; Ajzen, 1991) consider the impact of attitudes, subjective sociocultural norms, and perceived behaviour control on psychological help-seeking. Although the TPB constructs have been deemed universal, it has been suggested that the degree to which each factor influence's behaviour may vary cross-culturally (Mo & Mak, 2009; Pilkington et al., 2012). For example, in collectivistic societies, social pressures play a greater role than in individualistic cultures,

as found by a review Adams et al. (2022). Where the TPB has been applied and extended by explicitly including cultural factors, the model's explanatory power has been improved (e.g. Qi & Ploeger, 2019).

Such research extending the TPB underscores the need to consider factors specific to ethnic minority groups. These may include factors such as stigma, alternative models of distress, misidentification of needs, and cultural exclusion within services which are known to contribute towards discrepancies in access to support for ethnic minority groups (e.g. Gureje et al., 2006; Mclean et al., 2003; Memon et al., 2016; Punthmatharith et al., 2007; Rabiee & Smith, 2013).

In order to support ethnic minority fathers during their NCU stay as well as in their transition to fatherhood, specific knowledge about their experience is required. To the author's knowledge, there are currently no studies focusing on the barriers to accessing psychological support in the NCU for this group.

Project Background and Aims

This project was commissioned by a level 3 NCU which is part of three neonatal networks in the South of England. The unit is classified as a Neonatal Intensive Care Unit (NICU), which provides the highest level of care and including surgical and cardiac services to new-born babies who are ill or born prematurely.

The staff team supporting this service consists of a variety of medical staff, including but not limited to consultant neonatologists, medical trainees, and a large nursing team. Other allied health professionals include a feeding team, physiotherapists, an occupational therapist, a speech and language therapist, and a small team of clinical psychologists.

Psychological support is available to all parents on the NCU, however, the psychology team report that fathers are less likely to seek, or take up, an offer of support. Although approximately one third of families on the unit are from ethnic minority backgrounds, fathers from these backgrounds are even less likely to engage with the psychology service. It is currently unclear how many ethnic minority fathers refuse psychological support as the channels through which this may be offered are numerous.

This study therefore aims to understand the barriers to psychological support for these fathers. In line with GIRFT report (GIRFT, 2022) recommendations that the parental voice must be heard, this study adopts an interpretive view and sought fathers' own stories via one-to-one interviews.

Method

Participants

Seven fathers from ethnic minority backgrounds participated in this study. Demographic details are available in Table 1.

Table 1

Participant Demographics

Demographic Variable	***N***	**%**
Age		
20-30	1	15
30-40	4	57
40-50	2	29
Ethnic Background		
South Asian	5	71
Australasian	1	15
Caribbean	1	15
Duration of NCU Stay		
0-1 months	1	15
1-2 months	1	15
2-3 months	2	29
3-4 months	2	29
4-5 months	1	15
Accessed Psychology		
Yes	2	29
No	5	71

Researcher's Background and Preconceptions

The researcher is a British-Pakistani, Trainee Clinical Psychologist who is visibly Muslim due to her observation of hijab (Islamic code of modesty). Her ethnic minority status aided in establishing rapport and trust, enabling participants to discuss sensitive

cultural issues and experiences. However, participants may also see her as ‘one of them’, making them less likely to elaborate on their responses. Care was therefore taken to assume a curious approach and clarify participants’ responses as necessary. The researcher does not have children of her own, but her cultural background means she analysed the data through a lens of familiarity with a hesitance to seek support for mental health across a variety of settings.

Patient and Public Involvement

Three fathers from ethnic minority backgrounds with NCU experience were given the opportunity to input into and shape the project. Specifically, this included the participant information sheet, consent sheet, the semi-structured interview schedule. One father also provided feedback on the analysis.

Materials

A semi-structured interview schedule (Appendix E) was designed for this study, with a focus on broad questions on positive and negative experiences of the NCU. A flexible approach was adopted to allow participants to bring forth experiences important to them.

Procedure

Parents whose babies were being discharged from the NCU were given a form requiring their consent to be contacted about service evaluation and improvement projects on the unit. Parents who signed this form were screened in line with the following inclusion criteria:

- Identification with an ethnic minority group (i.e. any non-White-British group)

- Over the age of 18
- No experience of infant fatality
- Duration of stay on the unit exceeding 3 days in the last 24 months

Parents meeting the criteria were emailed and fathers who expressed an interest were sent a Participant Information Sheet (Appendix F) and Consent form (Appendix G).

Interviews were conducted via Microsoft Teams and lasted between 43 and 65 minutes. Interviews were recorded and transcribed with permission of the participants using the inbuilt Microsoft Teams function. At the end of each interview, participants were sent a debrief form (Appendix H).

This project was approved by the Psychological Medicines Governance Committee and classified as a Service Evaluation by the Study Classification Group in October 2021.

Data Analysis

Interviews were analysed using Reflexive Thematic Analysis with a combined inductive and deductive approach (Braun & Clarke, 2006, 2021). This allowed the exploration of a range of possible themes and is effective in highlighting key patterns within exploratory data. This methodology also amplifies the fathers' voices, allowing their views to influence the service. A critical realist position was adopted: assuming that participants' motivations, perspectives, and experiences reflect a truth about their world, while recognising that these are filtered through the researcher's own assumptions and experiences (Braun & Clarke, 2022, p.169).

A second rater coded one full interview which enabled reflexivity and dialogue. Inter-coder reliability was not calculated as it contradicts the interpretative agenda of qualitative research (Clarke & Braun, 2013; O'Connor & Joffe, 2020) by suggesting there is single, objective, external "reality" for these fathers. To increase trustworthiness and

credibility, we have presented contextual information, multiple examples of raw data, attended to deviant cases, and have benefitted from an ethnic minority father with NCU experience providing feedback on the legitimacy of analytic interpretations.

Full details of the steps of analysis and triangulation of data are provided in Appendix I, and further examples of raw data for each theme are provided in Appendix J. To preserve anonymity of our interviewees, all potentially identifying information from extracts has been removed.

Findings

Fathers reported a diverse range of experiences of support as well as barriers to accessing the psychology service on the unit. These are summarised in Table 2 below.

Table 2

Summary of Themes and Subthemes

Theme	Subtheme
1. Psychology is a Threat	1.1. Needing to be Strong
	1.2. Incompatible with Masculinity
2. It's Not Really Talked about in our Culture	
3. A Space for Mum, Not Me	

Theme 1: Psychology is a Threat

In this theme, we explore how fathers perceived psychologists as a threat, both in the acute NCU environment where they felt a need to be strong to protect their families in the face of significant adversity, as well as to live up to expectations of masculinity in

wider society. Although this pressure to conform to expectations is experienced cross-culturally, we explore how it is distinctly nuanced and piqued for these fathers.

Needing to be Strong

Fathers in our study described expectations of them to "*play the supporting role*" (P3). To do this, they had to *be* and *appear to be* strong, as one father described needing to be "*the vision of strength*" (P1).

This father (P4) elaborates on the need for him to be strong:

> *"I had to cover myself with probably a stronger shield at the time. If I was broken down, then it would have been even more difficult for my wife to cope with the situation. So, I had to put that shield on. I had to be strong at the time and I did, I think."*

We see here a father shielding and protecting himself in order to support his wife. There is a sense that if he were to 'break down' under the weight of their experience, he would be adding to the burden already felt by the couple. Other fathers shared this need to protect, and described feeling "*guarded*" (P1) and "*defensive*" (P3) in the NCU.

For many, the weight of this expectation was experienced as challenging, as this father (P4) describes:

> *"I had to ensure that look, I was carrying her as well as the whole situation. Umm, so yeah it was you know. Difficult. I'll just say it was very…probably the most difficult time of my life."*

By reacting to the most difficult time in his life by 'carrying' his wife as well as 'the whole situation' we see not only the sense of responsibility felt by this father, but also an active and sometimes practical response in the face of difficulty.

In order to support others, fathers felt unable to attend to their own emotional turmoil, and saw expressions of emotions as destabilising and counterproductive. They described strategies to disengage emotionally, such as "*keep your emotions at bay*" (P1), "*brushing*

off comforting phrases from family" (P5), and "*bottle it up and throw it away and lock it somewhere*" (P1).

Psychologists were seen as a threat to their efforts to maintain composure:

> *"Well of course there's a fear towards the psychologist. The man may feel that, generally they feel that, it's a threat to them. And that they're going to be exposed."(P6)*

This fear of being 'exposed' and made vulnerable by a psychologist was shared by another father who stated that a psychologist may "*prod you to a point where you kind of break down in a heap*" (P1), or "*poke buttons that will make you feel more vulnerable than you already are*" (P1).

When viewed more positively, psychologists were described as "*a sounding board*" (P5) or someone to "*vent to*" (P7), but were not seen as being able to provide active coping strategies or support for fathers to 'be strong'.

Incompatible with Masculinity

Accessing psychological support was also seen as incompatible with understandings of masculinity and fatherhood. Here, an interviewee (P6) describes a father figure as someone who can cope without any external support:

> *"He's strong enough to deal with his own concerns, and he doesn't need anybody to guide him in any direction. Who has any concerns, he should be able to manage and navigate the situation by himself. If other people are supporting you, then how are you a man?"*

This father identifies an inherent conflict between 'being a man' and accessing support or relying on others to help him cope. The same father explains how seeking support is explicitly associated with stigma:

> *"If you're going to psychologist and if you're a man, then that means you're going there because you're mad, because, you're crazy. For women its easier, but if you're a man, then there's a perception of a stigma."*

This father draws attention to gender-based narratives around help-seeking, which for men, are laden with labels such as "*mad*" or "*crazy*" (P6, P7). Other consequences for men who seek support included "*diminishing their sense of manhood*" (P6), becoming "*ostracized*" (P7), and being perceived as "*weak*" (P3, P5, P6, P7).

Cultural understandings of poor mental health involved attributing blame to the individual in distress, such as a result of their committing sin, or as "*karma*" (P7), or having "*a devil or jinn inside them*" (P7). This stigma contributed to a hesitancy to seek support, as one father stated: "*people are worried and scared about coming forward." (P7).*

Fathers who did seek support, did so in private spaces away from the main ward. Often this was sought from other fathers; recognition of shared experiences seemed to be enough to overcome the potential tarnishing of their masculinity or fatherhood. Fathers who did seek support (from other fathers or from staff) chose not to disclose this to their partners or families.

Theme 2: It's Not Really Talked about in our Culture

The choice to not access support, or to not share acts of help-seeking may be understood through the lens of cultural norms and expectations. This theme explores the impact of generational and familial beliefs, norms around sharing negative news, and culturally appropriate coping strategies.

A number of fathers talked about drawing support as well as their own coping styles from their families. In this extract, a father (P5) describes why the generation above him may not understand seeking support on the NCU:

> *"In history in terms of our elder parents and the older generations like especially in Pakistan, it was quite common that you know, you'd have*

> *many children. […]and they would pass away. And like, you know, just, that's what happens. It's just a kind of 'get over it' kind of situation almost. […] They would just see it as normal life as opposed to an event, that this is something that requires something more than that, they might question what's the need for it (psychology) basically."*

The generational difference in how the loss of a child is experienced and processed makes help-seeking behaviours harder to justify. His description suggests that women in the generations above him would also be expected to 'get over it'. This may add another level to his fear of emasculation whereby in comparison, his need for support as a man, is even less understood.

He goes on to compare accessing support on the NCU to the acceptability of seeking support for an event such as a car accident:

> *"But as for the accident, it's like okay, something negative has happened[…]Because that wouldn't be seen as every day, they'd say, okay, something else happened. You know, they would tell family, oh, you know, she had an accident, whereas they wouldn't like for miscarriages and things like that. They're not really, they're not really talked about in our culture, for sure."*

This father carves clear distinctions between events that are 'talked about' and therefore sought support for, as compared to 'non-events', or that which is silenced, such as miscarriage. Other fathers spoke about the cultural framing of a baby's birth as positive event, such as: "*a baby being born, obviously in our culture is a very, very positive thing*" (P7). It may therefore feel harder to access support for an event which is perceived socially as positive albeit in challenging circumstances.

The impact of culture on sharing information was talked about by other fathers, one of whom described their NCU experience as "*a private time*" (P4). Here a father (P3) explains why in his culture, the loss of, or hospitalisation of a baby is not shared:

> *"So in our culture…you don't, you don't, share negative news.[…] And so I think there's this test, and you keep yourself to yourself and don't get too many people involved because you don't know their intentions and*

> *everything else. […] so that that kind of links itself to the 'just get on with it', and kind of you know, do what you need to do behind closed doors, put on a face for the world kind of thing."*

Here we see the cultural expectation of this father to cope privately, and to pretend to cope in front of others. Other fathers spoke of coping strategies which were in line with cultural and religious practices, such as engaging in private prayer.

Theme 3: A Space for Mum, Not Me

The idea of fathers needing to cope in private was reinforced by perceptions of who the psychology service was for. In this final theme, we discuss this in terms of fathers viewing support as necessary for mothers, and their perception of psychology as female dominated.

Fathers in our study recognised the benefits of their partners accessing support. Here, a father (P2) describes his wife's need for support given her experience of pregnancy and premature labour:

> *"Because the mums, are the ones that goes through the labour and the pregnancy and the sickness and the, the, the nine months building up to up to having a baby and in our case 28 weeks and then having to go through baby being born and so I can understand where a mum's mental side would suffer more than the dad's."*

His understanding of why his wife's mental health may suffer is grounded in the corporeal experiences of pregnancy and childbirth, without which, support is not seen as necessary. This idea was reinforced by fathers noticing that the psychologists were often interacting with mothers on the unit:

> *"I guess if I did have reservations of doing it and then every time I saw them, they were talking to other women. Yeah, I guess it probably would kind of further enhance those reservations because you might just think that's not a space for me. That's for mum."* (P3)

Whether they could access the service as men was also influenced by the fact that the psychology team on the NCU were all women: "*a panel of like three women as well. Like it's kind of very, very female*." (P3).

Practical barriers added to the perception that the psychology service is for mothers, including time pressures and the office hours of the team:

> *"Your visits to the hospital are post working hours and the counselling team are only visible kind of in your core working hours. You probably gonna get a mismatch…And then you kind of got that discord of if you're only there for a couple of hours, do you wanna spend an hour of it talking to someone or do you wanna spend it with your kid that you've kind of, you've been away from all that time?"* (P2).

Fathers are therefore left in a position of having to choose between spending time with and supporting their families and accessing support for themselves. The 'mismatch' described here is reflected throughout this analysis not only in the practical sense of who the service is for, but also at the intersection of cultural norms and gendered expectations.

Discussion

The aim of this project was to understand the barriers experienced by ethnic minority fathers when accessing psychology support on the Neonatal Care Unit. These barriers largely pertained to the perceived consequences of accessing support both in the immediate NCU setting, as well as wider social costs, cultural norms around having a baby on the unit, and perceptions of the service as being for mothers. We see from our sample that ethnic minority fathers are not only influenced by the social norms of their gender, but also their cultural beliefs: it is this intersectionality that marginalises their ability to access support.

The barriers to help-seeking in our data can be understood through a lens of sociocultural norms, where for ethnic minority fathers, salient cultural factors may compound gendered expectations around how masculinity *should* be enacted (Baia et al., 2016; Noergaard et al., 2016). These barriers are evidently multi-layered: at a microlevel through the need to be strong to protect their partners and newborns, enacted as a mesolevel through familial norms and expectations which may be multigenerational, and at a macro level where hegemonic masculinity and stigma dictates a need to be emotionally stoic and self-sufficient.

These findings add to growing literature on the differences in experience of support between mothers and fathers, with fathers primarily experiencing the NCU as outsiders (see Govindaswamy et al., 2020). The idea of needing to be the 'strong partner' is also in line with previous research (e.g. Hagen et al., 2016), but central to the stories in this study is the perception of psychologists as a threat.

It was notable that the fathers we spoke to perceived support to be primarily for the mothers and did not have an understanding of the role of an NCU psychologist. Some fathers' understanding of a psychologist's role was based on their exposure to psychological or wellbeing ideas in their places of employment, including the need for a confidential space, and as someone to talk to about anxiety. Despite this, they described the role of the psychologist as one that could have been fulfilled by any other member of staff, as one father highlighted, "you could be speaking through to anybody really". This issue was compounded by the perceived lack of visibility of the psychology team, as fathers highlighted that they were unable to build rapport with the psychologists, and were therefore more likely to speak to other staff.

Another finding central to this study is the impact of stigma as a result of cooccurring and interacting social identities. This is in line with a recent scoping review

which highlights how aspects of public (social) stigma drives experiences of self-stigma in men across the lifespan (McKenzie et al., 2022). Moreover, the men in this study were able to articulate and locate their resistance to help-seeking in the pressure they felt to uphold hegemonic ideals of masculinity. Morrow et al. (2020) suggest that steps should be taken to enable groups of ethnic minority men to join together and consciously acknowledge the impact of stigma on help seeking, as well as benefit from the positive impact of exposure to each other to reduce self and social stigma.

Although not explicitly applied in the analysis, the findings from this project fit with the Theory of Planned Behaviour (Ajzen, 1991), in that attitudes towards masculinity and mental health, and sociocultural norms were factors which contributed towards help-seeking. Future research may consider the applicability of this theory to this population in a more systematic way.

Limitations

Given the tendency of the homogenisation of People of Global Majority's experiences, it is important to recognise that this project speaks to the experiences of a small number of fathers without acknowledging nuanced differences in culture, faith, or language. The small sample size may be a reflection of the barriers discussed above. Further information is needed on how non-English speaking parents experience the NCU as only one non-English speaking father participated in this study through an interpreter.

Service Recommendations

In line with the above findings, a number of recommendations can be made to the service. These are summarised in Table 3, and expanded upon below:

Table 3

Summary of Recommendations

Recommendation
1. Information sharing about the role of a psychologist through physical advertising;
2. Improved access through a range of online and physical resources in the main languages spoken on the unit;
3. Increased visibility of the psychology team achieved through adequate staffing provision;
4. Consideration of stigma when all MDT staff approach fathers on the unit with training for this as required;
5. Adopting an integrated approach to knowing families in relation to their cultural context;
6. Independent fathers' room or group for fathers to foster mutual support;
7. Systematically collecting written feedback from fathers

Firstly, there is a need for clearer information sharing about the role of neonatal psychologists as part of the multidisciplinary staff team. The importance of effectively communicating what psychological services offer is highlighted in the IAPT BAME Black, Asian and Minority Ethnic Service User Positive Practice Guidelines (BABCP, 2019). On the NICU, this may be achieved via leaflets targeted at fathers which explain the psychologist's role as tripartite, to support the baby's development, containing and supporting the family system around the baby (with a focus on the father's role in this), as well as providing support to the staff team who subsequently support both parents and

baby. Leaflets may also include alternative sources of support such as the charity sector, links to Facebook groups, and other support networks. Such leaflets can be created and shared at a network level to mitigate time and staffing limitations in each individual unit and provide parity if and when babies transfer to different units.

Further physical advertising such as posters emphasising support provision for fathers (by including quotes from fathers, and photos of men) may also highlight support available. In line with Social Identity Theory (Tajfel, 1981), the inclusion of quotes and photos of fathers in physical advertising may increase in-group ties while reinforcing the acceptability of fathers accessing the service. A strengths-based approach targeting building resilience and providing coping strategies for fathers may challenge perceptions of psychology as a threat, and has been recommended as an alternative to traditional Western psychiatric models which are deficit-focussed (e.g. Jones et al., 2007). The service may conduct an audit to identify the main languages spoken on the unit and subsequently translate leaflets and posters.

A range of resources may improve accessibility in the NICU. The lack of tailored advertising of mental health services has been recognised elsewhere, such as in studies on young men (e.g. Lynch et al., 2016). The service is currently developing a bank of online resources, the link to which could be shared with fathers via email, or through QR codes on posters on the unit. Furthermore, specific physical resources for fathers such the Neonatal DadPad which contains practical advice and signposting may also be beneficial. The findings of this project may support funding applications for such resources.

Secondly, there is a need for greater familiarity and improved visibility of the psychology team on the unit. To achieve this, adequate staffing provision is necessary. Recently published staffing standards of neonatal psychology (ACP UK, 2022) highlight that this unit is below the national standards and whilst increasing staffing levels is

currently not feasible the team may create videos online introducing themselves and their role.

Thirdly, there is a need to consider the way in which fathers are approached and the relevance of stigma to this. As fathers may be informed about psychological support by doctors and nurses, medical staff who may inadvertently perpetuate stigma may benefit from training. Training should be on-going as research finds short-term positive impacts, which diminish over time (e.g. Eiroa-Orosa et al., 2021). Approaching fathers in more private spaces or offering fathers the option to email or telephone the service may soften fears of feeling and being seen as vulnerable on the unit. It is crucial that staff hold stigma in mind in all interactions with fathers on the unit. This begins from the language used when support is offered. For example, focusing on support for the family system and encouraging fathers to engage in non-specific conversations may distance the offer of support from any associated stigma.

The unit may also benefit from a ‘father’s room’ independent to the existing ‘family room’ as a space for fathers to feel safe, build a shared identity, and seek support from each other. This is line with findings by Morrow et al. (2020) who highlight the need for ethnic minority men to connect and acknowledge stigma in order to reduce it. Although the hospital footprint is a significant limitation to this, such shared spaces may also be facilitated through fathers’ groups. However, given the tension in how fathers choose to spend their time, attending a group may be less desirable.

Fourthly, more information on other relevant culture or faith-based perceptions and norms related to having a baby on a NCU is needed. Knowing families in relation to their contexts including shared values, group ideas and identity facilitates an understanding of needs and concerns, and subsequently may enable fathers to access psychology support. This process of enquiry is one that should be adopted by the entire NCU staff team and

may consequently contribute to more sensitive and holistic care. The wider staff team may benefit from attending training on considering such factors in their day-to-day interactions with fathers.

Finally, an annual family experience questionnaire which collects demographic data, as well as giving fathers feedback forms to elaborate on their decision to access or not access psychology support will add to the reliability and validity of the barriers found in this project.

Dissemination

These findings have been discussed with the Service Lead and local Neonatal Operational Delivery Networks lead and have also been presented at the Trust's Quality improvement governance Away-Day.

Conclusion

Ultimately, the findings from this study add to previous literature which emphasise the need for NCUs to be inclusive of fathers in support provision, as well as a need to understand factors relevant to being from an ethnic minority background for insight into additional sources of burden, as well as coping. Health services must consider the intersectionality of culture and gender to be more aware of the barriers to access.

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Theory Driven Research Project

The Effect of Acknowledging Religion on Expectations of Therapy in British Muslims: A Mixed-Methods Study

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Abstract

Objectives: The underrepresentation of British Muslims in UK mental health services necessitates an understanding of barriers and facilitators to engagement in therapy.

Design: This mixed-methods online study explored the impact of explicitly acknowledging religion on anticipated alliance, treatment credibility, and expectations of therapy in British Muslims.

Methods: A video-vignette experimental design was used in which participants who self-reported as either high or low in religiosity were randomly allocated to receiving information about Cognitive Behavioural Therapy either with or without an explicit mention of religion as a value in the therapeutic process. Qualitative data were collected via a free-text box.

Results: The results suggest that acknowledging religion does not impact upon anticipated alliance, the primary dependent variable. However, scores on the closely related secondary variables, perceived credibility of therapy and treatment expectation, were significantly higher when religion was explicitly mentioned by the 'therapist'. A thematic analysis of free text across all participants found three main themes: '*We are Too Different'*, '*It's Not Worth the Risk'*, and '*What we Need for Therapy to Work*'.

Conclusions: These findings suggest that mentioning religion as a value to be considered in therapy positively impacts upon how therapy is perceived by British Muslims.

Keywords: British Muslim, Therapy, CBT, Therapeutic alliance, credibility, expectancy

Over the last decade there has been an increased focus on access to psychological services for minority groups (e.g. Hussain et al., 2022; Lawton et al., 2021; Loewenthal et al., 2012). Recent Talking Therapist data (IAPT Data Set Reports, 2018) calls attention to the underrepresentation of British Muslims, who have poorer treatment outcomes than White British and ethnic minority service users from other religious backgrounds (Baker, 2020; Mir et al., 2019). Research indicates low levels of trust in mental health services in British Muslims, as well as clients feeling their spiritual needs are not accommodated in treatment (Mir & Sheikh, 2010). Fears that clinicians in a secular setting may minimize, misinterpret, or even pathologize religious beliefs are also documented (Byrne et al., 2017; Islam et al., 2015; Mayers et al., 2007; Naeem et al., 2010). A possible consequence of this is that instead of seeking professional help, British Muslims may prefer to use religious coping techniques (Loewenthal et al., 2001); faith identity is therefore an important focus for understanding engagement with mental health services.

Factors Influencing Attitudes Towards Accessing Psychological Services

The decision to engage with psychological services has been linked to several factors which are influenced by cultural and religious beliefs. These include treatment expectations, which reflect prognostic beliefs or feelings about the effectiveness of treatment (Constantino et al., 2011), as well as treatment credibility, which represents a personal belief about a treatment's logicality, suitability, and efficacy (Devilly & Borkovec, 2000). Clients' prognostic beliefs about the consequences of engaging in treatment may depend, in part, upon how credible the therapy seems. Credibility and outcome expectation are positively correlated (Ametrano et al., 2017; Constantino et al.,

2014), and they each explain a unique portion of variance in client outcomes (Mooney et al., 2014; Smeets et al., 2008), suggesting they are distinct factors.

Another important factor which may mediate the relationship between treatment credibility, expectancy, and outcomes is the Therapeutic Alliance (TA). The Therapeutic Alliance is the collaborative relationship developed interpersonally between therapist and client through the course of therapy (Bordin, 1979). The alliance has been consistently linked to better outcomes across psychotherapies; the most recent metanalysis exploring over 306 studies on the alliance-outcome relationship confirms the robustness of the positive relationship between alliance and outcome (Flückiger et al., 2018).

Bordin (1994) conceptualises the alliance as having three distinct aspects: agreed-upon goals of therapy (goal), means of obtaining the goals (tasks), and the relationship between client and therapist (bond). If clients do not agree with the goals and tasks of therapy, or believe that the therapist does not understand their problem in the same way as them, they may perceive treatment as not credible and inadequate for their needs, and may have lower outcome expectations (D'Aniello et al., 2019).

Considerations of Faith Differences

Research exploring the development of the therapeutic alliance draws on social psychology literature suggesting that people tend to identify with individuals who are perceived as similar to themselves (e.g. Wintersteen et al., 2005). In therapy, perceived similarity may contribute to the development of greater initial trust based on a shared identity (Thompson et al., 2004; Wong, et al., 2003). Where there are differences between therapist and client in valued domains, such as in the context of British Muslims and non-Muslim therapists, it may be valuable to attend explicitly to a client's religious beliefs,

especially if the client views religion as a strong influence in their life. This idea is supported by an American study of majority Christian participants which found that participants higher in religiosity predicted higher alliance in response to an invitation to address religious issues in therapy via a written consent form (Shumway & Waldo, 2012). Such research supports the idea that incorporating religious beliefs into therapy may contribute to the development of strong alliances in secular settings.

The Current Study

This study sets out to gain an understanding of whether explicitly addressing religious values impacts on expected therapeutic alliance, perceived credibility, and expectation of treatment for British Muslims. The following research questions are proposed:

1. Does acknowledging the importance of religion as a specific value improve expected alliance with the therapist for Muslim participants?

2. Does acknowledging the importance of religion as a value for Muslim participants improve their perception of treatment credibility and expectation of outcome?

3. Are the above effects associated with the extent to which individuals self-identify as religious?

It is hypothesised that acknowledging religion as a value for Muslim participants will improve their expectations of therapy in terms of anticipated alliance with a white British therapist seen in a video vignette. This will be assessed relative to a statement regarding a more general acceptance of the person's values. Additional effects on

treatment credibility and overall treatment expectation are also hypothesised, and that these will be associated with level of religiosity.

Method

Design

A randomised mixed-methods experimental design was used to test the study hypotheses. Stratified randomisation was used based on levels of religiosity (high vs low) to one of two conditions: control condition (a video which referred to respecting values in general), and an experimental condition (a video in which religion was explicitly acknowledged). Participants completed measures after the baseline video, and subsequently completed the same measures after either the control or experimental video. A free-text box was used to collect qualitative data at the end of the study.

Participants

Inclusion criteria were being over the age of 18 and identifying as British Muslim. Exclusion criteria were current or past experience of psychological therapy and having professional knowledge of Cognitive Behavioural Therapy (CBT). The exclusion criteria were chosen due to their potential influence on participants' perception of therapy, for example previous successful or unsuccessful attempts at integrating faith-based beliefs into therapy. The study was approved by the University of Oxford's Central University Research Ethics Committee (MRA-19/20–19,878; Appendix L).

Participants were recruited between June and August 2022. Advertisements (Appendix M) were shared on social media (Whatsapp, Linkedin, and Twitter) as well as by relevant networks such as the Muslim Researcher's Network, and the British Islamic Medical Association. Participants who clicked on the link were taken to an information

sheet and asked to give consent in line with inclusion and exclusion criteria. If they did not consent, they did not proceed with the study. All responses were anonymous.

Sample Size

An a priori power analysis was conducted using G*Power3 (Faul et al., 2007) based on the primary dependent variable: expected alliance. A medium effect size (*d* = .50), and an alpha of .05 were specified, indicating that 128 participants were required to achieve a power of .80.

Measures

The study measures were self-report questionnaires characterising the groups alongside the hypothesis testing variables (see Table 1). Full scales are available in Appendix N.

Table 1

Outcome Measures Used within the Study

Domain	Measure
Grouping variable	
Religiosity	The Centrality of Religiosity Scale (CRS; Huber & Huber, 2012) is a 15-item Likert-scale questionnaire which measures five core dimensions of religiosity: public practice, private practice, religious experience, ideology and the intellectual. The CRS has been validated for Muslim populations, for whom specific modifications were suggested and applied to this study (see Huber et al., 2020).
Primary Outcome Variables	
Expected Therapeutic Alliance	The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006; Horvath & Greenberg, 1989) is a 12-item measure of the strength of the therapeutic alliance and its three components; goals, tasks, and bond. The WAI-SR has been adapted in previous studies by changing past and present verbs to the future tense so that it relates to expected alliance (See Nordgren et al., 2013; Shumway & Waldo, 2012).
Credibility and Expectancy	The Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000) is 6-item questionnaire which measures treatment credibility and expectation of outcome. It explores whether treatment appears logical; if the treatment appears useful; and if the treatment is reliable. The outcome expectation items explore the improvement that the client thinks will probably occur; if the client feels that this therapy will help them; if the client feels that improvement will occur. The measure utilises two rating scales, one from 1 to 9 and another from 0 to 100%. In line with recommendations by Devilly and Borkovec (2000), each item was standardised for the present analysis.
Secondary Outcome Variables	
Anxiety and Depression	The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) is a 14-item scale with 7 items measuring depression and 7 measuring anxiety. The HADS was used to evaluate if chance differences in clinical symptoms which occurred during randomisation influenced the findings.
Demographics	Participants provided their age, gender, ethnicity, and religious sect.

Stimuli

Video vignettes featuring a young female White-British therapist (representative of therapists in primary care mental health services) wearing an National Health Service lanyard were created for this study. The scripts for these three vignettes are available in Appendix O. Cognitive Behavioural Therapy was chosen as the therapeutic modality as it is the most prevalent form of psychological therapy offered in UK primary care services. The script and videos were piloted with several British Muslims whose feedback was used to inform the final videos. A built-in timer-function on Qualtrics was used to ensure that participants could only move to the next stage of the study after the video had finished playing.

Baseline Video (Video 1)

All participants were shown the baseline video, which was 1 minute 59 seconds, in which the therapist explained the CBT model, including the building of a shared understanding based on patterns of unhelpful thoughts and behaviours, identification of goals, and active and collaborative experimentation.

Control Video (Video 2)

Participants in the control condition were then shown a 44 second video, which featured the same therapist, who expressed their belief in the importance of understanding clients' values in therapy.

Experimental Video (Video 3)

Participants in the experimental condition were shown a 59 second video, which again featured the same therapist, who instead of referring to general values, explicitly

mentioned the importance of discussing religion in therapy if it was felt to be important. This is in line with Johnson et al.'s (2007) recommendation that therapists offer an explicit statement communicating their openness to exploring religion with clients as a method to integrate religion into therapy. The script of the experimental video was similar to the control video except for the mention of religion.

Procedure

Participants first completed the Centrality of Religiosity Scale, the score of which determined the stratified random allocation to either the control condition or the experimental condition. Participants were randomised by a built-in tool on Qualtrics which uses the Mersenne method of generating pseudo-random numbers (Matsumoto & Nishimura, 1998). All participants were then shown the same baseline video, in which they were given a brief description of CBT and what therapy entails. They subsequently completed baseline measures of anticipated alliance, treatment credibility, and expectation. Depending on condition allocation, participants were then shown either the control video (mentioning general values), or the experimental video (explicitly mentioning religion). Participants then repeated the measures of anticipated alliance, credibility, and expectation of improvement.

After completing the measures for the second time, participants completed the HADS and demographic questions, and were given a free textbox asking: "Do you have any comments about the videos or your experience of completing this study (including your views on therapy with a non-Muslim therapist)?". On completion, participants were shown a debrief form with a list of contact numbers if they felt distressed or would like further professional support.

Analysis

The analysis was performed using IBM SPSS Statistics v27 following the strategy shown in Table 2.

Table 2

Quantitative and Qualitative Analytic Strategy

Quantitative Data
Statistical assumptions were checked and met for each analysis. Change scores in anticipated therapeutic alliance ratings were calculated by subtracting total alliance scores at T1 from those at T2. Group differences were analysed using 2(low vs high religiosity) x2(video condition allocation) Between-Subjects Analysis of Variance (ANOVA) tests.
Qualitative Data
A structured tabular approach to conducting Thematic Analysis based on guidance by Robinson (2022) was used, which is grounded in the reflexive thematic analysis approach of Braun and Clarke (2006, 2019). This methodology allowed the exploration of a range of possible themes and is effective in highlighting key patterns within a large set of data. Data from participants across both video conditions were analysed together as initial coding indicated similarities between the narratives in both conditions. Full details of the steps of analysis and triangulation of data are provided in Appendix P, and further examples of raw data are provided in Appendix Q. To preserve anonymity of the participants, all potentially identifying information from extracts has been removed.

Results

A total of 417 participants started the study online: 231 participants' data were excluded due to incomplete responses, 24 participants' data were excluded as they failed to complete watching the videos before responding (due to an error in the inbuilt timer function), and a further 13 were excluded for having professional experience of *delivering* therapy, leaving a total of 129 participants. 68 participants were allocated to the control condition (n = 40 High Religiosity, n = 28 Low Religiosity) and 61 to the experimental condition (n = 36 High Religiosity, n = 25 Low Religiosity).

Descriptive Statistics

Table 3 shows participant demographics including the distribution across ages, with 78.3% of participants between the ages of 21-50. Most participants identified as being Sunni Muslims (89.9%) and 65.1% of participants were female.

Table 3

Participant Demographics

Demographic Variable	***N***	**%**
Age		
18-20	18	14.0
21-30	38	29.5
31-40	27	20.9
41-50	36	27.9
51-60	5	3.9
61-70	3	2.3
70+	1	0.8
Prefer not to say	1	0.8
Religious Sect		
Sunni	116	89.9
Shia	3	2.3
Ahmadi	2	1.6
None	7	5.4
Prefer not to say	1	0.8
Ethnic Group		
African	7	5.4
African Asian	4	3.2
Arab	10	7.8
Arab Asian	1	0.8
British Asian	22	17.1
Asian Other or Asian Unspecified	9	7.0
Bangladeshi	11	8.5
Indian	6	4.7
Pakistani	42	32.6
White British	8	6.2
Other	5	3.9
Prefer not to say	4	3.1
Gender		
Female	84	65.1
Male	44	34.1
Prefer not to say	1	0.8

Comparison of Groups for Descriptive and Demographic Variables

Examinations of group differences suggested that they are comparable on key demographics. Table 4 below shows descriptive data divided by groupings based on religiosity and allocation to condition.

Ethnicity was collapsed into three categories: Asian, Asian British, and Other. Chi squared tests indicated there was no significant association between religiosity and ethnicity, $X^2_{(2)}$, (N = 125) = 5.25, $p > 0.05$, or between religiosity and sex, $X^2_{(1)}$, (N = 128) = .11, $p > 0.05$. There was also no significant association between religiosity and sect, whereby sect was categorised into Sunni and 'Others'; ('unspecified' sect was not included), $X^2_{(1)}$, (N = 116) = .978, $p > 0.05$.

Chi squared tests indicated that there was a significant association between religiosity and age, $X^2_{(7)}$, (N = 128) = 19.98, $p < 0.05$, where participants in the lower religiosity group had a mean age category of 3.19 (30-40yrs), and participants in the higher religiosity group had a younger mean age category of 2.68 (20-30yrs). Despite this, age was not significantly correlated with change in alliance (r=.056, $p > .05$), change in credibility (r=.007, $p > .05$), or change in expectancy (r=.105, $p > .05$), and was therefore not used as a covariate in the analysis. There was no main effect of religiosity on HADS-A scores $F_{(1,125)}$ = .015, $p > 0.05$ or on HADS-D scores $F_{(1,125)}$ = .763, $p > 0.05$.

Table 4

Participant Descriptive Data

Variable		Control video (*n*=68)		Experimental video (*n*=61)	
		High Religiosity (*n*=40)	**Low Religiosity (*n*=28)**	**High Religiosity (*n*=36)**	**Low Religiosity (*n*=25)**
Age					
	18-20	4 (22.2)	4 (22.2)	9 (50)	1 (5.6)
	21-30	13 (34.2)	4 (10.5)	12 (31.6)	9 (23.7)
	31-40	18 (66.7)	9 (33.3)	10 (37)	8 (29.6)
	41-50	9 (25.7)	13 (37.1)	7 (20)	6 (17.1)
	51-60	2 (33.3)	1 (16.7)	0 (0.0)	3 (50.0)
	61-70	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)
	70+	0 (0.0)	0 (0.0)	1 (100)	0 (0.0)
Sex					
	Male	13 (29.5)	9 (20.5)	14 (31.8)	8 (18.2)
	Female	23 (27.4)	16 (19)	26 (31)	19 (22.6)
Sect					
	Sunni	32 (27.6)	24 (20.7)	35 (30.2)	25 (21.6)
	Other	3 (60.0)	0 (0.0)	1 (20.0)	1 (20.0)
Ethnicity					
	Asian	24 (35.3)	12 (17.6)	17 (25)	15 (22.1)
	Asian British	2 (9.1)	7 (31.8)	7 (31.8)	6 (27.3)
	Other	9 (25.7)	5 (14.3)	16 (45.7)	5 (14.3)
		M (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)
HADS-A Score		9.11 (4.16)	8.04 (4.91)	7.65 (5.03)	8.93 (4.99)
HADS-D Score		6.39 (4.29)	6.20 (3.73)	5.13 (4.1)	6.57 (3.78)

Primary Analysis: Anticipated Therapeutic Alliance

Prior to main analysis, anticipated therapeutic alliance was compared between those relatively higher and lower on self-reported religiosity at baseline (i.e. After the first video). These groups were comparable on this variable (high religiosity: $M = 41.34$, $SD = 8.01$, low religiosity: $M = 40.38$, $SD = 9.15$), $t_{(127)} = -.635$, $p > .05$. This indicated an equivalent starting point for religiosity groups on the primary variable before

randomisation to the additional video. Means are shown in Table 5 below, together with those for the secondary analyses.

The main analysis next considered the impact of the two videos on the primary variable; change scores in anticipated therapeutic alliance ratings were calculated by subtracting total alliance scores at T1 from those at T2. A 2(low vs high religiosity) x2(video condition) between subjects ANOVA was then used to compare the change in scores of anticipated therapeutic alliances between the control condition and the experimental condition. In terms of change in anticipated alliance, the main effect of video condition was not significant, $F_{(1,125)} = .638$, $p > 0.05$. There was also no significant main effect of religiosity on change in anticipated alliance, $F_{(1,125)} = .217$, $p > 0.05$. There was no evidence of an interaction between participant religiosity and the allocated video condition $F_{(1,125)} = .004$, $p > 0.05$.

A paired-sample t-test showed a significant increase in therapeutic alliance from T1 to T2 across both video conditions. On average, participants rated the therapeutic alliance as higher at T2 ($M = 43.95$, $SD = 8.11$) than at T1. This increase in alliance rating was significant $t(128) = 5.946$, $p < .001$, indicating that increased exposure to the putative therapist may have positively impacted on the expectation of a good therapeutic alliance.

Secondary Analyses

Credibility of Treatment

At baseline, participants in high and low religiosity groups did not differ in terms of credibility (high religiosity: $M = 18.86$, $SD = 4.21$, low religiosity: $M = 18.24$, $SD = 4.31$), $t(127) = -.802$, $p > .05$, indicating an equivalent starting point.

A 2(low vs high religiosity) x2(control vs experimental video) between subjects ANOVA to predict the change in participants' rating of treatment credibility did not show a significant main effect of religiosity, $F_{(1,125)} = .662$, $p > 0.05$. However, the main effect of video condition was significant, $F_{(1,125)} = 9.130$, $p < 0.05$. Participants in the experimental condition showed a greater improvement in rating of treatment credibility (M = -1.97 SD = 3.49) than participants in the control video condition (M = -0.43, SD = 2.38). The interaction between video condition and religiosity was not significant, $F_{(1,125)} = .480$, $p > 0.05$, indicating that the inclusion of acknowledgment of religious values improved treatment credibility regardless of degree of religiosity.

Expectancy of Change

At baseline, participants in high and low religiosity groups did not differ in terms of expectancy (high religiosity: M = 16.28, SD = 4.42, low religiosity: M = 16.27, SD = 4.73), $t(127) = -.014$, $p > .05$, indicating an equivalent starting point.

A 2(low vs high religiosity) x2(control vs experimental video) between subjects ANOVA with the change in rating of expectancy as the dependent variable did not show a significant main effect of religiosity, $F_{(1,125)} = .012$, $p > 0.05$. However, the main effect of video condition was significant, $F_{(1,125)} = 4.767$, $p < 0.05$. Participants in the experimental video condition had a greater change in expectancy (M = -2.22, SD = 3.46) than participants in the control video condition (M = -1.07, SD = 2.40). The interaction between video condition and religiosity was not significant, $F(1,125) = .034$, $p > 0.05$. This result is similar to the treatment credibility findings.

For both credibility and expectancy, the Levene's test of homogeneity of variance was close to significant; visual inspection of the distributions (Appendix R) indicated that

there were variations in kurtosis, most likely related to less variance in the control video. Distributions were generally close to normal, and it is unlikely that this issue accounted for the findings.

Table 5

Means and Standard Deviations of Primary and Secondary Measures

Variable	**Control video (*n*=68)** ***M* (*SD*)**		**Experimental video (*n=61*)** ***M* (*SD*)**	
Change in Alliance	-2.60 (5.50)		-3.44 (5.99)	
Change in Credibility	-0.43 (2.38)		-1.97 (3.49)	
Change in Expectancy	-1.07 (2.40)		-2.22 (3.46)	
	High Religiosity (*n*=40) ***M* (*SD*)**	**Low Religiosity (*n*=28)** ***M* (*SD*)**	**High Religiosity (*n*=36)** ***M* (*SD*)**	**Low Religiosity (*n*=25)** ***M* (*SD*)**
Change in Alliance	-2.78 (5.58)	-2.36 (5.49)	-3.67 (5.29)	-3.12 (6.98)
Change in Credibility	-0.4 (2.64)	-0.46 (1.99)	-1.64 (3.28)	-2.44 (3.8)
Change in Expectancy	-1.09 (2.69)	-1.05 (1.98)	-2.16 (3.13)	-2.31 (3.96)

Qualitative Analysis

Across the range of views expressed by British Muslims in this study, we identified an overarching tension between faith and therapy which related to perceived incompatibility, captured in Theme 1, as well as intergroup differences, captured in Theme 2. Participants also suggested ways to overcome these barriers, summarised in Theme 3. Participants have not been allocated numbers or pseudonyms as no participant is quoted more than once.

Theme 1: We are Too Different

Participants identified "*fundamental beliefs that are different*" between themselves and non-Muslim therapists, including differences in "*world view*", and "*values and purpose in life*". Subsequently, a number of participants felt that they would not be understood:

> *"I don't think they can be fully invested in me if they don't understand and share my motivations for self-purification - a non-Muslim therapist might help me fix the problem at the surface level but I'm not confident they will be able to get to the root of the problem"*.

In referencing the therapist's lack of full 'investment', she suggests that the therapist's connection with her would also be compromised, and perhaps superficial. This idea was shared by other participants, as one expressed "*there will always be a degree of a block between myself and a non-Muslim therapist*".

Participants located the 'root' of their problems in a faith-based understanding, this conceptualisation of mental health and faith as interconnected meant that non-Muslim therapist could attend only to one part of the problem. This is exemplified here by this participant talking about the 'Islamic end goal' of attaining God's pleasure:

> *"Unless she (the therapist) herself believes in the Islamic end goal, she cannot truly help you on a journey she does not see the target to. Some companions are able to help partially yes, but the true companion is the one who walks with you to the destination IMO [in my opinion]."*

The therapist here is not able to be a 'true companion', and crucially is not able to see the target that the client would like to reach.

Some participants shared alternative tools and strategies which were felt to fit better with their faith beliefs. These included preventative strategies as well as mechanisms to cope with distress:

> *"We already have strategies for coping with stressors in the form of trust in Allah, salah [obligatory prayers], dua [calling out to God], strong family and community ties etc."*.

Others likened connecting with God to a form of therapy, this was seen as more acceptable than therapy with another person:

> *"As Muslims, we have been taught a great importance of connecting with Allah, and so created a kind of therapy where we share about feelings and wishes in Duas…so I can see the view of some people not wanting therapy with anyone including non-Muslims."*

Theme 2: It's not Worth the Risk

Participants also shared relational concerns, such as worries about trust and their sense of safety in therapy with a non-Muslim therapist. Intergroup differences, for some, were felt to be too big to be overcome in therapy. These are explored in this second theme.

Many participants referenced feeling more "*comfortable*" with a Muslim therapist. For some this was related to worries about how those of faith are viewed by others:

> *"Non-Muslim people tend to just not understand what it really means to be religious, and without realising it they tend to harbour quite patronising attitudes towards religious people"*

Others worried about being judged for their practice of faith, as this participant expresses:

> *"I would be worried that a non-Muslim therapist would be judgemental about my faith, I'm a very conservative Muslim and believe that sharia [Islamic law] should be adhered to strictly."*

For some, this negative judgement was linked to the threat of being reported to the authorities. This participant describes the threat of being reported to *Prevent*, the UK Government's national counter-terrorism programme:

> *"…(I) theoretically may think it's useful, but worry about being referred to Prevent etc. Just for being a Muslim and for Muslim cultural or religious practices…this would affect my ability to safely access therapy as it's not worth the risk."*

For this participant, the risk of being reported overshadows any potential benefits of therapy. Other participants shared this mistrust, stating: "*I would probably never be completely open with them [non-Muslim therapist]*".

Yet other participants shared concerns that by engaging in secular therapy, they may be led them away from their faith by advice which is 'haram':

> *"(I) May feel uncomfortable when discussing Islamic issues with a non-Muslim as they may give me advice that may go against my religion".*

Here, the therapist is framed as giving advice from a position of misunderstanding, with consequences of moving Muslim clients further away from the 'Islamic end goal' mentioned previously.

Theme 3: What we Need for Therapy to Work

Participants also shared what would be needed to overcome barriers. For most, this was a sense that the therapist understood, respected, and was able to incorporate faith into treatment. The extent of this varied between participants; some wrote of the value of a "*spiritually connected therapist*", and others of "*a non-Muslim who has some knowledge of Islam*". Ultimately, the incorporation of religion was felt to "*overall increase the chances of success*". Here a participant describes their desire for therapy to reflect Islamic principles and values:

> *"…it makes me as a practising Muslim far more comfortable if the therapist respects my preference for an Islamic application of CBT, so that it can reflect the principles and values that are important to Muslims..."*

In this next extract, the participant recognises advantages of having a non-Muslim therapist, but with the precondition of incorporating faith beliefs into therapy:

> *"I actually think that getting a varied viewpoint is helpful, so having a non-Muslim therapist may be helpful if they are truly understanding and incorporating Islamic beliefs and principles."*

Some participants shared other characteristics that were felt to be important to them in a non-Muslim therapist, including cultural sensitivity, gender matching, and lack of judgement and preconception. An understanding of culture was sometimes seen as more important than religion:

> *"I believe therapy is very beneficial, equally with a muslim or non-muslim therapist as long as they are understanding of certain cultural differences"*

Other participants prioritised the therapists' skills and qualities:

> *"I think the religion of the therapist is not massively relevant, what's most important is the ability to understand deeply how someone is feeling and be empathetic with a good set of tailored support."*

This importance of the therapist to 'understanding deeply' is a thread that is woven through our analysis.

Discussion

This study focused on the reactions of British Muslim participants to a White British therapist describing a specific psychotherapeutic intervention (CBT). The impact of the therapist acknowledging the importance of considering specific religious values in the context of developing a therapeutic relationship prior to delivering therapy was evaluated by randomisation to conditions where the importance of incorporating religious values in therapy was or was not emphasised. Neither religiosity nor video condition had an effect on change in expected alliance. There was, however, a positive effect on alliance across both video conditions and across religiosity groupings. Moreover, the acknowledgment of religious values in the description of therapy had a positive impact on both treatment credibility and expectation of outcome; religiosity grouping had no impact on these variables.

There is only one other quantitative study to examine these issues (Shumway & Waldo, 2012) which found an interaction between level of religiosity and anticipated working alliance. Their study did not utilise video stimuli, relying instead on a written consent form, and they did not consider religiosity as a variable when allocating participants to control or religion conditions. Furthermore, they do not exclude participants with previous experience of therapy, which may impact responses above and beyond the experimental design.

Previous qualitative studies on British Muslims' perceptions of therapy are also limited. Weatherhead and Daiches (2010) found through interviews that participants emphasised the value of respecting and acknowledging their faith in therapy. In the qualitative part of the present study, participants identified barriers of difference and understanding, the risk of harm through therapy, and a desire for religion to be incorporated into therapy. The qualitative findings of a need to be understood support the quantitative findings, exemplified here by one participant in the experimental condition (explicitly mentioning religion), who wrote: *"Second video definitely removes any automatic disconnect with therapist. By default, seeing a non-muslim therapist may already remove some effectiveness as the sense of understanding isn't there but the second video reassures this is something that they understand"*.

The incorporation of religious beliefs in therapy involves therapists taking responsibility for engaging clients in these discussions without seeing their own epistemological position as truth (Carone & Barone, 2001; Lee et al., 2022). To facilitate discussion around the compatibility between faith and therapy, non-Muslim therapists should have an understanding of the basic tenets and beliefs of Islam (Abu Raiya & Pargament, 2010). An awareness of fears including anti-terrorism strategies, discrimination, and worries about being exposed to anti-religious beliefs is also important in addressing relational dynamics and intergroup differences.

An important feature of the present study was that the control video indicated that the therapist would respect their clients' values, with the experimental condition simply indicating that this would explicitly include religion. This very subtle difference in emphasis significantly impacted perceived effectiveness and credibility of treatment. Pre-existing religiosity did not interact with this effect, suggesting that the acknowledgement

of religion may be effective for British Muslims across a range of religiosity. These findings are consistent with previous research (e.g. Meer & Mir, 2014) indicating that when working with Muslim clients, non-Muslim therapists should clearly demonstrate an openness to discussing faith. Furthermore, as increased exposure to the therapist also increased anticipated alliance regardless of condition, pre-treatment interventions involving the therapist providing more information could improving expectancies.

There are a number of limitations of the present study. Data on participants' education level or inter-generational differences were not collected, both of which may be variables of interest. Furthermore, only English-speaking participants with internet access and familiarity with online forms could participate in this study: this particular group is likely to have more exposure to information about therapy and mental health services online. Note also that the video-vignettes provide an explanation of CBT but did not provide insight into the actual content of therapy. Future research may show segments of therapy to allow participants to better judge their anticipated alliance with the therapist.

In terms of research implications, further work is needed to understand the relationship between anticipated alliance and credibility/expectancy. This study found significant effects in credibility and expectancy but not alliance; future research may test this relationship more explicitly. There is also a need for studies testing the predictive validity of the future-tense versions of the WAI. Further interview studies aimed at understanding how therapy with a non-Muslim therapist is perceived may also elucidate the barriers and facilitators to therapy for British Muslims.

In conclusion, this study found that treatment credibility and expectancy of outcome for a CBT intervention were improved by showing participants a video in which a White British therapist explicitly acknowledged the importance of religion. Qualitative

findings highlight a need to attend to issues of compatibility and intergroup dynamics, as well as the need to understand and incorporate religious beliefs and values into therapy.

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Executive Summary

British Muslims are less likely to access mental health services than other minority groups. There is currently limited research exploring why this may be. When considering how people make decisions about whether to access therapy or not, the following three factors are often considered:

- Credibility of treatment: Beliefs about how logical, suitable, and effective treatment is
- Treatment expectations: Beliefs or feelings about how effective the treatment will be
- Therapeutic alliance: The strength of the relationship between the client and the therapist, including their agreement on the goals of therapy and how these goals will be achieved.

This study aimed to understand how British Muslims perceive therapy in relation to the above factors when religion was or was not explicitly mentioned as being part of the therapy process. There were 129 participants who completed an online study in which they first completed a questionnaire measuring their level of religiosity (how religious they are). Depending on their score, they were either categorised as having ‘high religiosity’ or ‘low religiosity’. The online programme they used to complete the survey then randomly allocated them to two separate video groups; participants did not know which video they were allocated to, but half of those allocated to each video were high in religiosity, and half low in religiosity.

All participants then watched a video in which a White British therapist explained a type of therapy called Cognitive Behavioural Therapy. After watching the video, they were asked to imagine having therapy with the therapist in the video and answered some

questions which measures their expected alliance with the therapist, how credible they thought the treatment would be, and their expectancy of the effectiveness of the treatment. After this, participants were shown a second video, depending on which group they were randomly allocated to at the start. In one group, participants were shown a video in which the same therapist mentioned the importance of understanding their values in therapy, and in the other group, the same therapist *explicitly* mentioned the importance of understanding their religious beliefs if they were important to them. After this second video, the participants filled out the same questionnaires about alliance, credibility, and expectancy. Finally, participants answered questions about their mood and anxiety, and were given a text-box to share their thoughts on the survey and on how they felt about having therapy with a non-Muslim therapist.

The study predicted that acknowledging the importance of religion as a value for Muslim participants would improve their perception of therapy in terms of expected alliance, treatment credibility and overall treatment expectation. It also predicted that this would depend on how religious the participants were, so participants who were more religious were expected to show a greater improvement in perception of therapy. The data from the survey were analysed and results indicated the following:

- There was not a significant difference in how participants rated therapeutic alliance regardless of their religiosity, and regardless of which video they saw.
- Across both the video groups, participants showed an improvement in alliance from the first to the second video.
- There was a significant difference in ratings of credibility and expectancy of treatment: participants who were shown the video in which religion was mentioned rated credibility and expectancy as higher than those who were shown the video in

which religion was not mentioned. However, this did not depend on how religious the participants were.

The data from the textbox question were also analysed and three main themes were found:

1. "*We are Too Different*" – this theme explored how different participants expressed they felt to a non-Muslim therapist, and how this would negatively impact upon the therapists' ability to understand and connect with them. This theme also included the alternative forms of coping that participants felt they were able to draw upon.
2. "*It's not Worth the Risk*" – this theme focused on the concerns participants shared about the harm that could be done to them through therapy, including being judged negatively, being reported to anti-terrorism organisations, and being given advice that goes against their beliefs.
3. "*What we Need for Therapy to Work*" – this theme delved into what participants felt would help them engage with therapy. This included religious beliefs and values being incorporated into therapy, as well as other factors including therapists being culturally sensitive and being empathetic and skilful.

Overall, these findings suggest that it is beneficial for therapists to explicitly state that religion can and should be discussed in therapy if it is felt to be important to the client. Further research is needed to understand the barriers to therapy for British Muslims, as well as things that make it easier for them to engage with therapy services.

Reflective Narrative

The following is a reflective account of the process of conducting the research projects presented in this thesis. Although at first glance, these three projects appear very different from one another, they are all connected by the core theme of understanding and improving (access to) psychological support for minority groups.

Theory-Driven Research Project:

My interest in this area stems from experiencing British Muslims in my own community being reluctant to access psychological therapy. I was supported by a senior research tutor, Louise, to design a simple but elegant study to explore factors that may impact perceptions of therapy. The additional layer of qualitative data collection enabled me to explore and incorporate narratives and stories directly from participants.

Recruitment for this study involved some unexpected challenges. While I reached the number of required participants in a matter of days, I found most participants had started, but not completed the study. I was also conscious that my study was being shared in University group-chats, thereby skewing the level of education among my sample. I subsequently made efforts to contact local community groups and mosques, but was disappointed that these were not fruitful avenues of recruitment. This left me wondering why my own community was reluctant to engage in research that I naively viewed as obviously beneficial for them; I reflected on my own assumptions and expectations, and wondered whether by training to be a clinical psychologist, I had also become the ‘other’.

The findings of this project were exciting. Significant differences in the perceived credibility of therapy and treatment expectation filled me with hope. Barriers shared in qualitative reports were similar to those I have previously heard in my own

community. I was surprised, however, at the strength of expressions of feeling ‘too different’ to engage in therapy. I was conscious of the impact of this finding in further distancing British Muslims from secular services and therapists. I reflected on the mismatch between my quantitative findings which provide ideas and space for change, while my qualitative findings suggest a fundamental and potentially irreconcilable difference. I hope in future, to explore this gap further.

Service Improvement Project

This project stemmed from being interested in disruptions to early attachment experiences. A preliminary reading of the literature around the neonatal intensive care environment led me to wonder about the experiences of ethnic minority groups, and the intersection here with fatherhood. I expected there to be a discrepancy in help-seeking for ethnic minority fathers and this was confirmed by the service, who were eager to understand and improve this.

As anticipated, recruitment was particularly difficult. Ethnic minority fathers who did not want to engage with psychology, understandably did also not want to engage with research on the topic. Contacting families soon after discharge was particularly uncomfortable for me; I felt that I was intruding on a fragile family unit still finding its feet away from an intensive hospital environment. I exhausted multiple avenues of recruitment and was bound by time to stop recruiting after my seventh participant. I am comforted by the knowledge that the value of qualitative research is not measured by the number of those represented, but by the richness and representation of their narratives.

Psychologists are perceived as a threat to religious values and cultural family-based beliefs in my own community, so the finding that the psychologists on the NICU were seen

as a threat, albeit for different reasons, was of particular interest to me. It highlighted a need for further education about the role of psychologists across a range of settings. Furthermore, I was surprised at the impact of generational norms around help-seeking as well as the pervasiveness of stigma in an environment in which stressors are clear and visible to all.

Critical Review of the Literature

The process of conducting a systematic literature review was the most difficult part of my research journey. Due to anxiety, I avoided fully immersing myself in the process which not only wasted time, but was also disheartening as it led to me having to repeat steps multiple times. Ultimately, I learnt by making mistakes. The main mistake being an incomplete search strategy, which due to the conflation of the terms 'culture' and 'religion' in the literature base, resulting in me having to re-run my search and finding an additional 3500 records to review after having already completed data extraction on my first search.

Due to the heterogeneity of studies and designs included in my review, the synthesis process was perplexing; I struggled to find examples of similar reviews and benefitted from guidance from my tutor and supervisors as well as my own judgement in my write-up. Despite this, my interest in the topic was maintained throughout and I continued to explore relevant literature even after the painstaking search process.

On the 6th of May, I wrote on Twitter: "*I am never ever ever ever […] ever ever ever doing another systematic literature review ever again*" followed by, "*My way of being is not systematic. I am impatient and excitable, I like interpretation, chaos, and ambiguity. I like making gut decisions. I do my best work when things are messy*.". Now at the end of this process, I reaffirm my second statement; I have learnt that while I may not be systematic in my approach, this is to my strength and has benefitted me throughout training. However, I

have also gained enough confidence and satisfaction from conducting this review to reconsider my initial tweet.

Looking Forward

I feel a strong sense of responsibility for disseminating my findings in a way which enables meaningful change. I look forward to pursuing further research to bridge gaps between theory and practice for minoritized groups. In doing so, I hope to bring closer in understanding and amplify the voices of those our profession has yet to reach.

Acknowledgements

I recognise first and foremost the immeasurable bounties of my Lord, in giving me the faculties and the opportunities to engage in this work, and for providing me with the support necessary to complete it. I am under no illusion that this work is my doing and I pray for humility and grace as I move onwards.

My deepest gratitude to all the participants who contributed to these projects: for their generosity with their time and sharing of their stories.

To my research supervisors, Graham, Sarah, Paul, Jo, Fin, Jacinta, and Alasdair, thank you for your guidance and support. Thank you also to Louise, Myra, and the Librarians for helping when I was extra-stuck. A special mention to Ciorsdan, for being compassionate, funny, and giving great diplomatic advice.

To my beautiful family for their love and encouragement, and especially to my mum, for being my biggest cheerleader and making the dua's that have allowed me to get this far. To my husband, Faruq, for taking me on Hajj and multiple Umrah trips, and for laughing at me for having "only one degree" - a Doctorate trumps two Masters. To my Nana and Nani, who are no longer here but are a great source of inspiration to me: I know you would have been proud, and that only you would have been able to find the typos in this thesis.

Finally, to my friends and my cohort, who I could not have done this without.

Appendices

Appendix A: CRL Registration Details

This review was registered on PROSPERO (registration number CRD42023395834).

The protocol can be accessed here:

https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=395834

Amendments made since registration:

1) Qualitative studies added to types of study to be included.
2) Addition of Joanna Briggs Institute Tool for Qualitative Research added to risk of bias (quality) assessment.

Appendix B: CRL Search Strategy

Example of the search strategy used for PsychInfo:

1. Abraham* or Islam* or Christ* or Judai" or Muslim* or Moslem* or Allah or God* or Jew* or Religio* or Faith* or Spiritual* or Theolog* or Quran* or Koran* or "Qur'an" or Moral* or Cultur* or Blasph* or Bibl* or Catholic* or Protestant* or Rabbi or Torah* or Orthodox).ab, ti.
2. exp Religion/
3. religious affiliation/ or christianity/ or islam/ or judaism/
4. christianity/ or protestantism/ or roman catholicism/ or bible/ or christians/
5. muslims/ or islam/
6. judaism/ or jews/
7. "culture (anthropological)"/ or sociocultural factors/ or culturally adapted interventions/
8. faith/
9. morality/
10. spirituality/ or religiosity/ or religious beliefs/
11. obsessive compulsive disorder/
12. (OCD or "Obsessive Compulsive Disorder'" or "Obsessive Neurosis" or "Obsessive Compulsive Neurosis" or Scrupul* or "Obsessive-compulsive disorder*").ab,ti.
13. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10
14. 11 or 12
15. 13 and 14

Appendix C: CRL Risk of Bias Tools

Standard Quality Assessment Criteria for Evaluating Primary Research Papers

1. Question / objective sufficiently described?
2. Study design evident and appropriate?
3. Method of subject/comparison group selection or source of information/input variables described and appropriate?
4. Subject (and comparison group, if applicable) characteristics sufficiently described?
5. If interventional and random allocation was possible, was it described?
6. If interventional and blinding of investigators was possible, was it reported?
7. If interventional and blinding of subjects was possible, was it reported?
8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias?
9. Means of assessment reported?
10. Sample size appropriate?
11. Analytic methods described/justified and appropriate?
12. Some estimate of variance is reported for the main results?
13. Controlled for confounding?
14. Results reported in sufficient detail?
15. Conclusions supported by the results?

JBI Critical Appraisal Checklist for Qualitative Research

1. Is there congruity between the stated philosophical perspective and the research methodology?
2. Is there congruity between the research methodology and the research question or objectives?
3. Is there congruity between the research methodology and the methods used to collect data?
4. Is there congruity between the research methodology and the representation and analysis of data?

5. Is there congruity between the research methodology and the interpretation of results?
6. Is there a statement locating the researcher culturally or theoretically?
7. Is the influence of the researcher on the research, and vice- versa, addressed?
8. Are participants, and their voices, adequately represented?
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

JBI Critical Appraisal Checklist for Case Reports

1. Were patient's demographic characteristics clearly described?
2. Was the patient's history clearly described and presented as a timeline?
3. Was the current clinical condition of the patient on presentation clearly described?
4. Were diagnostic tests or assessment methods and the results clearly described?
5. Was the intervention(s) or treatment procedure(s) clearly described?
6. Was the post-intervention clinical condition clearly described?
7. Were adverse events (harms) or unanticipated events identified and described?
8. Does the case report provide takeaway lessons?

Appendix D: CRL Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

All papers published in the *Psychology and Psychotherapy: Theory Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological and social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

- theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
- behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
- psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

- systematic reviews following replicable protocols and established methods of synthesis
- qualitative and other research which applies rigorous methods
- high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

4. PREPARING THE SUBMISSION

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process. Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If

your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)*

Important: the journal operates a double-anonymous peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered. Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and

material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading ‘Practitioner Points’. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Acknowledgments;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
- Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);
- Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

Appendix E: SIP Interview Schedule

A. (Topic) General demographic information

1. One of the reasons you have been invited to participate in this study is because you are from an ethnic minority background. Can you tell me a little about this background? What was your upbringing like?

2. What is your family structure like?

    a) How many children do you have?
    b) Can I ask your age, only if you are happy to share this information?
    c) How old is your baby who spent time on the neonatal unit?

(Transition to the next topic: I am going to ask you a bit about your experience at the Neonatal Unit)

B. (Topic) General Neonatal Care Unit Experience

1. Can you tell me about your experience of your baby's hospital stay?

    a) What were your expectations of what the birth would be like - emotions
    b) How did you find out your baby was going to be taken into care - critical point
    c) How long was your stay in total?
    d) What led to your baby being on the unit?
    e) How did covid impact on your experience?

(Transition to the next topic: l am interested in the support you received while your baby was on the unit)

C. (Topic) Experience of support

1. Can you tell me about what support you drew on to cope during this time?
2. Can you tell me of a good experience of support?
3. Can you tell me about a bad experience of support?

(Transition to the next topic: I'm interested in psychological support specifically)

D. (Topic) Psychological support

1. What is your understanding of psychological support?
    a. Are there are cultural factors that contribute to this?
    b. Do you think your ethnic background contributes to this?
2. Were you offered support from the psychology team?
3. What point were you offered it, what was the context?
4. Did you receive any support from the psychology team:
5. Was mum offered psychology support from the team?
6. Why did you not take up psychological support offered by the psychology team?

7. Why do you think other fathers may take up psychological support?
    a. What do you think of fathers who take up this support?
8. Are there any barriers to you accessing support that you may need?

(transition to the next topic: And what about the service more broadly)

E. (Topic) Service Improvement

1) How well do you think the neonatal service meets your emotional or psychological needs?

a) What are the things the service does well?
b) What does it do less well?
c) What were your expectations of psychological support on the unit?
d) Did other families receive support differently to you?

Ending Transition: Thank you so much for sharing your story and experiences with me today. I really value your time. I'm confident that by listening and learning from experiences of fathers such as yourself. we can improve support for families, especially those from different backgrounds.

Appendix F: SIP Participant Information Sheet

Exploring Barriers to Accessing Psychological Support for Ethnic Minority Fathers with Babies on the Neonatal Care Unit

We would like to invite you to take part in our service evaluation. Before you decide, it is important that you understand why this evaluation is being conducted and what it would involve for you. Please take time to read this information and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask us.

What is the purpose of this project?

The purpose of this study is to better understand the experiences of fathers from an ethnic minority background who did not access psychological support whilst they had a baby on the neonatal unit.

Research suggests that fathers are less likely to access support during this time, and that those from ethnic minority backgrounds are even less likely.

Our team is eager to understand whether there are things we can do differently to support these fathers.

Who is organising and funding this project?

This study is a joint project between the Neonatal Unit at The John Radcliffe Department, and the Clinical Psychology Doctoral programme at the University of Oxford. It has not received external sponsorship or funding.

This project has been reviewed by the Trust's Research and Development Team as well as by the Psychological Medicine Governance Committee.

What are the inclusion criteria?

- You are the father of a surviving baby who has been on the unit for a minimum of 3 days in the last 24 months
- Your baby has been discharged from the neonatal unit
- You are over the age of 18
- You identify as being from an ethnic minority group (i.e. non White-British of any nationality)

Do I have to take part?

No. Taking part is entirely voluntary. If you do choose to take part, you can withdraw if you later change your mind, without giving a reason.

What will happen to me if I decide to take part?

If you decide to take part, you will be contacted by Trainee Clinical Psychologist, Hibah Hassan, to discuss any questions you might have. You will then be invited to attend an interview at a time that is convenient for you. Interviews will be conducted online via MS Teams and will take up to one hour. During this interview, Hibah will ask you questions about your experience of your baby's stay. This interview will be recorded to allow the researcher to transcribe and analyse it together with other participant's interviews.

What should I consider?

You will be asked to talk about your baby's stay on the unit, and may be asked questions such as "what was your experience of support from staff on the unit".

For some parents this is a difficult subject and can be upsetting. We ask you to consider whether this is something you feel comfortable having a conversation about.

If you do become upset at any point during the interview, the researcher will ask if you would like to continue. You are free to withdraw at any point without giving a reason. You will be offered the chance to speak to a clinical member of the team should you find this beneficial.

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

Fathers have helped develop the service evaluation. They have also been involved in reviewing this Participant Information Sheet.

What are the possible benefits of taking part?

Your participation in this evaluation will give us an insight into how we can better shape practices to support fathers like yourself.

Will my General Practitioner/family doctor (GP) be informed of my participation?

No, your GP will not be informed of your participation. If for any reason we had concerns about your safety, we would discuss with you regarding contacting your GP.

Will my taking part in the study be kept confidential?

Any and all information collected during this study is kept securely on Oxford University Hospital Trust computers.

Responsible members of the Oxford University Hospitals NHS Foundation Trust may be given access to data for monitoring and/or audit of the evaluation to ensure that the evaluation is complying with applicable regulations.

Recordings of the interviews will be destroyed post-transcription.

Will I be reimbursed for taking part?

Unfortunately, we are unable to reimburse participants for their time.

What will happen to my data?

We will be using demographic information you consent to provide us as part of this evaluation. Oxford University Hospitals NHS Foundation Trust researchers are responsible for looking after your information and using it properly. We will use the minimum personally-identifiable information possible.

We will store the anonymised research data and any research documents with personal information, such as consent forms, securely at the Oxford University Hospitals NHS Foundation Trust.

In accordance with the University of Oxford's and Oxford University Hospital's Policy on the Management of Research Data & Records, data will be stored for five years.

What will happen if I don't want to carry on with the study?

Participation is voluntary and you may change your mind at a later stage. It is important to note that after data analysis, it will not be possible to remove your data.

Withdrawal will not affect the care you receive from any relevant service.

What will happen to the findings of this study?

We aim to disseminate the findings widely so that they can benefit as many individuals, families, and services as possible. This may involve presenting findings at conferences and publishing findings in a journal. You will not be identified from any report or publication placed in the public domain.

If you would like to be provided with a summary of finding, please contact us at Hibah.hassan@ouh.nhs.uk

This evaluation will also contribute to the fulfilment of an educational requirement (e.g. a doctoral thesis).

What if there is a problem?

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this evaluation, you should contact the Patient Advice and Liaison Service (PALS) in the first instance (01865 221473), or at PALS@ouh.nhs.uk.

Thank you for considering taking part.

Appendix G: SIP Participant Consent Form

Exploring Barriers to Accessing Psychological Support for Ethnic Minority Fathers with Babies on the Neonatal Care Unit

Please click box

1. I confirm that I have read the information sheet dated 25.03.2022 (V4.0) for the titled project and that I meet the inclusion criteria. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my baby's medical notes and data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to these records. ☐

4. I understand that the information I provide as part of this study will be kept confidential and that the only exception would be if the researchers were concerned that I, or someone else, might be at immediate risk of serious harm. ☐

5. I agree to the interview being audio / video recorded for transcription and analysis. ☐

6. I understand that the research team will hold my personal details (e.g. name, contact details) for the duration of the study, in order to contact me for research purposes, and that following completion of the study, this information will be destroyed. ☐

7. I agree to take part in the above service evaluation. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix H: SIP Participant Debrief Form

Exploring Barriers to Accessing Psychological Support for Ethnic Minority Fathers with Babies on the Neonatal Care Unit

Thank you for taking part in this study, your time and effort are really appreciated.
If you know any other fathers from ethnic minority backgrounds who may like to participate in this study, you are welcome to provide them with our details here:
Hibah Hassan – Hibah.hassan@ouh.nhs.uk

Purpose of the study

This study aimed to gain a better understanding of the experiences and needs of fathers from minority ethnic backgrounds within the NICU and to explore the barriers to accessing psychological support that impact this group.
We want to use this information to make recommendations to the service to improve the identification of ethnic minority fathers who need support, and make changes to improve access to support
To remind you, all of your data is anonymous and confidential. We store the recording of your interview on a password protected computer, which can only be accessed by the research team. We will not keep any of your personally identifiable information, like the telephone number or email address you may have supplied to us to take part in this study. This information will be destroyed as soon as this study comes to a close in December 2023.

Further advice and support

If you are worried about your mental health, we encourage you to speak to your GP who can then refer you for further specialist help. You can also contact NHS 111.
There are also many charities who can provide advice, emotional and practical support including:

1. The Samaritans 116 123
2. Bliss (for babies born premature or sick) 020 7378 1122

If you would like specific support in relation to how you are feeling about your baby's stay on the unit, we can offer brief outpatient sessions. Please contact Hibah to discuss this.

Further questions

If you have any more questions about any aspect of this project, please speak to the researcher Hibah Hassan or her supervisor Dr Joanna Mann (Joanna.mann@ouh.nhs.uk), who will do their best to answer your query.
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you should contact the Patient Advice and Liaison Service (PALS) in the first instance (01865 221473), or at PALS@ouh.nhs.uk.

Appendix I: SIP Data Analysis

A critical realist position was adopted: we assumed that the participants' motivations, perspectives, and experiences reflect a truth about their world, while recognising that these are filtered through the researcher's own assumptions and experiences.

In line with guidance by Braun and Clarke (2006; 2021), interviews were first transcribed verbatim and identifiable information was removed. The transcripts were reviewed, and initial codes identified from this initial reading. Data under each code were collated and compared for similarities and discrepancies to ensure consistent coding. Connections between the codes were identified and codes with perceived connections were then combined into preliminary themes. Attention was paid to "negative cases" or data which might challenge the themes.

Themes were then named to demonstrate which aspect of the data they described and how they related to the study questions. The explicit meanings participants gave their experiences were retained as far as possible.

Bracketing exercises, including reflective discussions with colleagues, were conducted to raise awareness of potential biases and blind spots for the researcher.

Appendix J: SIP Examples of Raw Data

Theme 1: Psychology is a Threat

Subtheme: Needing to be Strong

“it’s kind of a case of like you, the dad, you're not the one that's giving birth. It’s essentially your responsibility to kind of kind of make sure that the whole family unit is together.”
“It was and I had to put this cover on. I had to put this. You know, collect bit more strength to cope with the situation”
“it's cause like other people or certain dads not wanting to kind of like show, I guess, show that the show their partner in some ways that they're kind of are going, they are going through about kind of mentally going through the bad time where they kind of expected to be the one, they're supposed to provide the support.”
“Um so I guess for from the dad's perspective, their focus is obviously their wife […] Whereas maybe the wives’ focus is obviously just making a difficult situation better. Um so maybe they don't want to document their own tension.”

Subtheme: Incompatible with Masculinity

“But it's not about a culture difference. It's not about, it's not about culture beliefs. It's really about being a man… the decisions that a man made to basically not accept help because they feel that that may diminish their sense of manhood.”
“I think I would be hesitant to speak to anybody outside my immediate family if I was seeking psychology support or had depression or anxiety or whatever because I would just you know, as I said to you that you would, you would be thought of as weak, basically”
“Yes, there is stigma for the man. OK, there is a belief that as a man, you have to be a man. In a way, it's socially acceptable to think that way for men. Yes, it is a stigma”
“It's like a masculinity thing, like, in a way that if I'm seeking help, it's not very masculine and or it's frowned upon because of where I'm from and what my culture would expect me to be like more of a man and providing and kind of just being the rock and not that kind of thing.”
“I think we just expected to kind of get on with it and our culture, but I think that's not, that's maybe not the cultural thing. That's probably also across cultures, it's more of a mass male versus female thing.”

Theme 2: It’s Not Really Talked about in our Culture

“I think that's especially in the Asian culture. I think that's probably the prevailing kind of thing. Um and I think it's kind of it's almost kind of admitting er weakness, which is very, very alien in the in the Asian culture to kind of go ohh I need, I need help. That's just generally, especially in the males, it’s not really done.”
“I mean it's very much seen as like you know you don't need to do that (seek psychological support). You can just you know pray more and you know that's it basically.”

“And I feel like, you know, even in my sort of family you were from Pakistan, kind of the men just don't have these conversations at all. To be seen to be struggling is kind of looked down upon.”
“It's just you wanted your own, you know, you just wanted your own space at the time. You just want to be spaced out from everything else. And just, you know, to reflect on what happened and, you know, sometimes it's best thing, we didn't want any interaction with any other person because then you have to go over the same thing over and over again.”
“So it in our culture, it's pretty, so you know you share positive news. And you don't, you don't, share negative excuse. And even you don't share positive news too much like, like, they're like, you know, you're gonna get like the evil eye or you're gonna get, you know, kind of what do you call it.”
“To some extent, I understand that and I think it's not sharing bad things that happen to you. Look, we went through an abnormal birth process. We had a baby that had lots of health problems. So everybody in the family and my friends around me have no experience of that. They have, they have, their understanding of birth is it’s some kind of beautiful process. Everything happens normally and everybody comes and they're all great. So I immediately knew that we would be perceived negatively.”

Theme 3: A Space for Mum, Not Me

“My wife struggled a lot more because she had a lot of the physical, but she went through all of it physically as well. So she obviously you know the trauma was a lot, lot more for her than it was for me. So she needed a lot more support.”
“Because I know the hospital here have SNAPP as well that kind of help you. But the thing about them, it's all women. There's no blokes whatsoever on the on the panel.”
“The kind of the mother and the mother's feeling is always put first, but then kind of to be, especially when you're kind of like first time dad then you're like alright, I don't know what any of this stuff is going on. And then you kind of thrust into NICU as well. Like it is a lot to take.”
“But otherwise you're kind of predominantly surrounded by kind of female females everywhere and I guess some people might not be as comfortable in in in talking to women. But yeah, I think especially from ethnic minority background as well because you might not feel that same degree of openness and talking to a guy, and they would do.”
“Well, I found kind of a lot of the moms around us were kind of a lot more engaged into in, into wanting to. And to be honest, every time I see the counselling team, they, they'd have a woman sat with them.”

Appendix K: SIP Author Guidelines

Journal of Reproductive and Infant Psychology

Preparing Your Paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

The abstract should be structured with a work limit of 250 words.

The required structure of the abstract is:
Aims/Background, Design/Methods, Results, Conclusion

Word Limits

Please include a word count for your paper.
A typical quantitative paper for this journal should be no more than 3500 words. The word limit excludes title, abstract, tables and references. The limit for a paper based on qualitative methods or systematic review is 5000 words.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.
Please use British (-ise) spelling style consistently throughout your manuscript.
Please use single quotation marks, except where ‘a quotation is “within” a quotation’.
Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s). Word templates are available for this journal. Please save the template to your hard drive, ready for use.
If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

References

Please use this reference guide when preparing your paper.

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Checklist: What to Include

1. **Author details.** Please ensure everyone meeting the International Committee of Medical Journal Editors (ICMJE) requirements for authorship is included as an author of your paper. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
2. Should contain a structured abstract of 250 words.
3. **Graphical abstract** (optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .tiff. Please do not embed it in the manuscript file but save it as a separate file, labelled GraphicalAbstract1.
4. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
5. Between 5 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
6. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
   For single agency grants
   This work was supported by the [Funding Agency] under Grant [number xxxx].
   For multiple agency grants
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
7. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.
8. **Geolocation information.** Submitting a geolocation information section, as a separate paragraph before your acknowledgements, means we can index your paper's study area accurately in JournalMap's geographic literature database and make your article more discoverable to others. More information.

9. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.
10. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.
11. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
12. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
13. **Units.** Please use SI units (non-italicized).

Using Third-Party Material in your Paper

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

Disclosure Statement

Please include a disclosure statement, using the subheading “Disclosure of interest.” If you have no interests to declare, please state this (suggested wording: *The authors report no conflict of interest*). For all NIH/Wellcome-funded papers, the grant number(s) must be included in the declaration of interest statement. Read more on declaring conflicts of interest.

Clinical Trials Registry

In order to be published in a Taylor & Francis journal, all clinical trials must have been registered in a public repository at the beginning of the research process (prior to patient enrolment). Trial registration numbers should be included in the abstract, with full details in the methods section. The registry should be publicly accessible (at no charge), open to all prospective registrants, and managed by a not-for-profit organization. For a list of registries that meet these requirements, please visit the WHO International Clinical Trials Registry Platform (ICTRP). The registration of all clinical trials facilitates the sharing of information among clinicians, researchers, and patients, enhances public confidence in research, and is in accordance with the ICMJE guidelines.

Complying With Ethics of Experimentation

Please ensure that all research reported in submitted papers has been conducted in an ethical and responsible manner, and is in full compliance with all relevant codes of experimentation and legislation. All papers which report in vivo experiments or clinical trials on humans or animals must include a written statement in the Methods section. This

should explain that all work was conducted with the formal approval of the local human subject or animal care committees (institutional and national), and that clinical trials have been registered as legislation requires. Authors who do not have formal ethics review committees should include a statement that their study follows the principles of the Declaration of Helsinki.

Consent

All authors are required to follow the ICMJE requirements on privacy and informed consent from patients and study participants. Please confirm that any patient, service user, or participant (or that person's parent or legal guardian) in any research, experiment, or clinical trial described in your paper has given written consent to the inclusion of material pertaining to themselves, that they acknowledge that they cannot be identified via the paper; and that you have fully anonymized them. Where someone is deceased, please ensure you have written consent from the family or estate. Authors may use this Patient Consent Form, which should be completed, saved, and sent to the journal if requested.

Submitting Your Paper

This journal uses Taylor & Francis' Submission Portal to manage the submission process. The Submission Portal allows you to see your submissions across Taylor & Francis' journal portfolio in one place. To submit your manuscript please click here.

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Please note that the *Journal of Reproductive and Infant Psychology* uses Crossref™ to screen papers for unoriginal material. By submitting your paper to the *Journal of Reproductive and Infant Psychology* you are agreeing to originality checks during the peer-review and production processes.

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Charges for colour figures in print are £300 per figure ($400 US Dollars; $500 Australian Dollars; €350). For more than 4 colour figures, figures 5 and above will be charged at £50 per figure ($75 US Dollars; $100 Australian Dollars; €65). Depending on your location, these charges may be subject to local taxes.

Appendix L: TDRP Ethical Approval

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Dr Graham Thew & Hibah Hassan
Oxford Institute for Clinical Psychology Training (OxICPT)
Isis Education Centre
Warneford Hospital
Oxford

11 January 2022

Dear Dr Thew and Hibah,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R79210/RE001

Study title: The Effect of Acknowledging Religion as a Value on Expectations of Therapy in British Muslims: Exploring Barriers to Help-Seeking

Short title: British Muslim's Perceptions of Psychological Therapy

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **18 months**, commencing on **11th January 2022.**

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix M: TDRP Recruitment Poster

British Muslims Needed:

TO PARTICIPATE IN AN ONLINE STUDY ON HOW MUSLIMS PERCEIVE PSYCHOLOGICAL THERAPY

UNIVERSITY OF OXFORD

You can participate if you:

- identify as British Muslim (practicing or not)
- are 18 years and above
- live in the United Kingdom
- have not had previous experience of therapy

What does the research involve?

This **online** study includes two short videos and some questionnaires, including questions about religious practices, and questions about the videos. **The study will take approximately 15 minutes.**

Click on the link or scan the QR code to participate

https://psychiatryoxford.qualtrics.com/jfe/form/SV_beJPPNjNfzBJx7o



Who is doing the research?

Salam, my name is Hibah and I am a Trainee Clinical Psychologist at the University of Oxford. I am interested in how British Muslims think about therapy. If you have any questions about this study, please get in touch at hibah.hassan@hmc.ox.ac.uk

Ethics Approval Reference R79210/RE001

Appendix N: TDRP Measures

Centrality of Religiosity Scale

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

Working Alliance Inventory - Short Revised

Please imagine that you are experiencing difficulties related to low mood or anxiety and are speaking to the therapist in the video you just watched.

Below is a list of statements and questions about the experience you would expect to have with this therapist. Think about the experience of therapy you would expect to have with her over the course of therapy, and decide which category best describes this.

	Seldom	Sometimes	Fairly often	Very often	Always
As a result of these sessions I am clearer as to how I might be able to change.	○	○	○	○	○
What I will do in therapy will give me new ways of looking at my problem.	○	○	○	○	○
I believe this therapist will like me.	○	○	○	○	○
This therapist and I can collaborate on setting goals for my therapy.	○	○	○	○	○
This therapist and I will respect each other.	○	○	○	○	○
This therapist and I will work towards mutually agreed upon goals.	○	○	○	○	○
I feel that this therapist will appreciate me.	○	○	○	○	○
This therapist and I will agree on what is important for me to work on.	○	○	○	○	○
I feel this therapist will care about me even when I do things that she does not approve of.	○	○	○	○	○
I feel that the things I will do in therapy will help me to accomplish the changes that I want.	○	○	○	○	○
This therapist and I will establish a good understanding of the kind of changes that would be good for me.	○	○	○	○	○
I believe this way of working with my problem is correct.	○	○	○	○	○

Credibility Expectancy Questionnaire

Therapy Evaluation Form

We would like you to indicate below how much you believe, right now, that the therapy you are receiving will help to improve your lifestyle / functioning. Belief usually has two aspects to it: (1) what one thinks will happen and (2) what one feels will happen. Sometimes these are similar; sometimes they are different. Please answer the questions below. In the first set, answer in terms of what you think. In the second set answer in terms of what you really and truly feel. We do not want your course convenors to ever see these ratings, so please keep the sheet covered when you are done.

Set I

1. At this point, how logical does the course offered to you seem?

1	2	3	4	5	6	7	8	9
not at all logical				somewhat logical				very logical

2. At this point, how successfully do you think this course will be in raising the quality of your functioning?

1	2	3	4	5	6	7	8	9
not at all useful				somewhat useful				very useful

3. How confident would you be in recommending this course to a friend who experiences similar problems?

1	2	3	4	5	6	7	8	9
none at all confident				Somewhat confident				very confident

4. By the end of the course, how much improvement in your functioning do you think will occur?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Set II

For this set, close your eyes for a few moments, and try to identify what you really feel about the course and its likely success. Then answer the following questions.

1. At this point, how much do you really feel that the course will help you to improve your functioning?

1	2	3	4	5	6	7	8	9
not at all				somewhat				very much

2. By the end of the course, how much improvement in your functioning do you really feel will occur?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Hospital Anxiety and Depression Scale

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Appendix O: TDRP Vignette Scripts

Baseline Video

Cognitive Behavioural Therapy, or CBT, is a psychological therapy for a variety of mental health problems. It takes a supportive, non-judgemental approach to a person's experiences of their difficulties. It is effective for specific disorders and difficulties relating to low mood and stress.

The word 'cognitive' refers to everything that goes on in your mind, including memories, images, thoughts, and attention. Behaviour refers to everything that you do, including what you say, how you try to solve problems, how you act, and what you avoid. CBT is based on the theory that these things are all connected and can maintain each other in helpful or sometimes unhelpful ways.

Within sessions, you and your therapist will explore the personal meanings of the difficulties you face, and how these may link to how you manage your symptoms. CBT is structured and practical, so once this shared understanding has been developed, you and your therapist will identify specific goals for you to work towards.

CBT is mainly concerned with how you think and act in the present. You and your therapist will work together to identify and interrupt current patterns of unhelpful thoughts or behaviours. This might be achieved through experimenting with different strategies between sessions. CBT is a collaborative therapy, your therapist will not tell you what to do, instead, they'll work with you to find possible solutions for your current concerns. By making small changes to your thinking and behaviour every day, you can start to impact upon your difficulties and quality of life.

CBT aims to equip people with skills through developing a self-management plan that you can continue to use once treatment has finished. This means that you are not reliant on your therapist and should make it less likely that your difficulties will return. If you have CBT on an individual basis, you will usually meet with a therapist for up to 20 weekly or fortnightly sessions, with each session lasting 30 to 60 minutes.

Control Condition Video

Research suggests that CBT is most effective when a good relationship is built between you and your therapist. To do this, your therapist may ask you about a number of aspects of your life and background. For example, understanding your values and what is important to you ensures that the therapy is meaningful and relevant to you and your life. We recognise that different people have different values and we encourage you to discuss these with your therapist.

Experimental Condition Video

Research suggests that CBT is most effective when a good relationship is built between you and your therapist. To do this, your therapist may ask you about a number of aspects of your life and background. For example, we recognise that for some people, religion is a very important value that impacts them in various ways. Understanding your religion and how it is important to you ensures that the therapy is meaningful and relevant to you and your life. If religion is important to you, your therapist will encourage you to discuss this in your sessions and will work with you to incorporate your religious beliefs and framework into the treatment process.

Appendix P: TDRP Qualitative Data Analysis

The qualitative data analysis followed guidance from Robinson's (2022) structured tabular approach, which is grounded in the reflexive Thematic Analysis process of Braun and Clarke (2006, 2019). A critical realist position was adopted: we assumed that the participants' motivations, perspectives, and experiences reflect a truth about their world, while recognising that these are filtered through the researcher's own assumptions and experiences.

The main researcher is a British-Pakistani Muslim woman. This placed her as an 'insider' to the participants as she holds in mind her own personal experiences of family members and friends engaging or not engaging with therapy services. She also considered own personal opinions on therapy with a non-Muslim therapist and paid attention to when participants either shared similar or opposing views to her own. Her position was considered throughout the analysis and bracketing exercises, including reflective discussions with colleagues, were conducted to raise awareness of potential biases and blind spots.

Qualitative data were exported into an excel spreadsheet and all identifiable information was removed. Data that were not relevant to the question and that could not be included in the analysis such as responses of "nothing to say" or "no" were excluded. Data that pertained purely to the quality of the questionnaire such as "the sound quality was poor" were also removed.

The remaining data were split into two: those from participants in the control condition and those from participants in the experimental condition. The data were then reviewed and initial codes were identified from this first reading. This process was iterative: the data were reviewed numerous times and codes were subsequently amended. Data under each code were collated and compared for similarities and discrepancies to ensure consistent coding. From these initial steps it was clear that codes and themes were similar across both video conditions. Patterns across both data sets related to shared narratives about a participant's experiences, views and perspectives. As all participants were asked the same question and the codes and preliminary themes across the data sets captured shared views, the two data sets were therefore combined.

The initial codes were reviewed again, connections between the codes were identified and codes with perceived connections were then combined into preliminary themes. Attention was paid to "negative cases" or data which might challenge the themes. Themes were then named to demonstrate which aspect of the data they described and how they related to the study question. The explicit meanings participants gave their experiences were retained as far as possible.

Appendix Q: TDRP Examples of Raw Data

Theme 1: We are Too Different

Where Muslims see a life of test and improvement, non-muslims may struggle to see beyond temporal pleasures unless they themselves are on some sort of spiritual path.
A non Muslim therapist wouldn't fully understand the belief system of Islam, and may lead to difficulties.
It's much easier to have therapy with someone who understands your values and purpose in life. That's not only true in therapy but right across all the relationships we have.
might be harder to connect to a non-muslim therapist/harder for them to understand your perspective on things
"I also feel like a non Muslim therapist can attempt to understand how I am feeling but will never truly get it in the same way as another practising Muslim."
Although I think therapy can be a very helpful thing to do, I as a practicing Muslim would prefer to see someone from within my own faith, as they may have a better understanding of my position as we are situated within the same framework.
I would always be awsre that a non muslim therapist or non practising muslim therapist did not have the same set of reliefs beliefs or shared religious understanding as me, so i would probably never be completely open with them
"Unless she (the therapist) herself believes in the Islamic end goal, she cannot truly help you on a journey she does not see the target to. Some companions are able to help partially yes, but the true companion is the one who walks with you to the destination IMO."

Theme 2: It's not Worth the Risk

I've heard of other Muslims having bad experiences with therapists - derogatory remarks about family size for example being related to their mental health problems.
I would be worried that a non-Muslim therapist would be judgemental about my faith, I'm a very conservative Muslim and believe that sharia should be adhered too strictly.
I wouldn't reccomend therapy because people can mess you up.
I think there might also be distrust of non-Muslim therapists because of the threat of being reported to counter-terrorism if you reveal disturbing thoughts.
I still feel there is a trust issue to work with non muslim therapist.
It may be hard sometimes for a non-muslim therapist to understand how religion can be more helpful than the actual therapy.
"It doesn't take into account that theoretically (I) may think it's useful but worry about being referred to Prevent etc. just for being a Muslim and for Muslim cultural or religious practices - this has happened in cases I know of personally and not just the

cases that are reported in the media and this would affect my ability to safely access therapy as it's not worth the risk.”
“people feel safer with a fellow Muslims and they trust that mental health problems are real and the therapy is real and works”

Theme 3: What we Need for Therapy to Work

I would prefer experience of the therapist over their religious beliefs!
I think for therapy to work for me, it would have to be framed from a religious perspective and context
If i were to consider engaging in therapy, connecting with the therapist is very important to me. The therapist doesn’t necessarily need to be Muslim but having a good understanding of faith and culture will help build a good working relationship
I think therapy is a positive thing to aid people if they need. I feel for Muslim it should Muslim therapist or a non Muslim who has some knowledge of Islam.
I actually think that getting a varied viewpoint is helpful, so having a non-Muslim therapist may be helpful if they are truly understanding and incorporating Islamic beliefs and principles
I would feel more comfortable if it was a Muslim therapist or even someone who was religious and believed in God.
I think the religion of the therapist is not massively relevant, what’s most important is the ability to understand deeply how someone is feeling and be empathetic with a good set of tailored support.

Appendix R: TDRP Homogeneity of Variance Distributions

Figure R1

Change in Credibility: Control Video

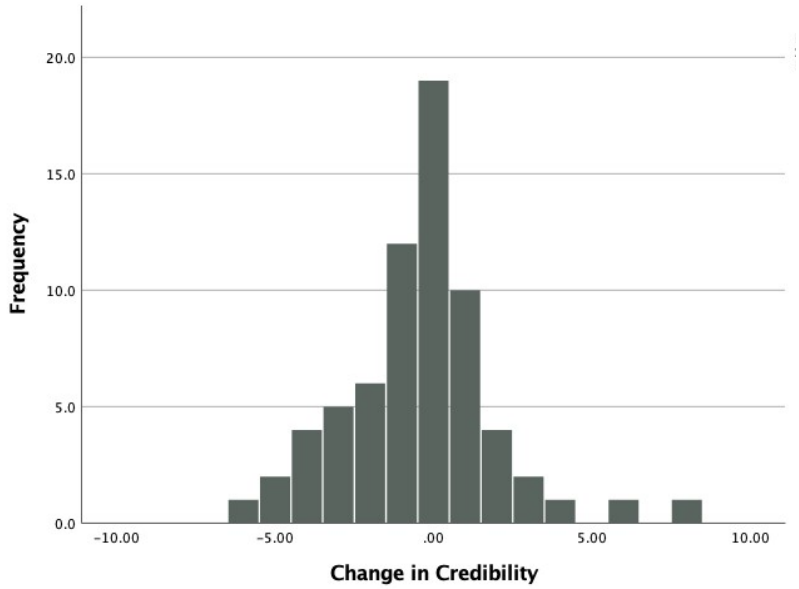


Figure R2

Change in Credibility: Experimental Video

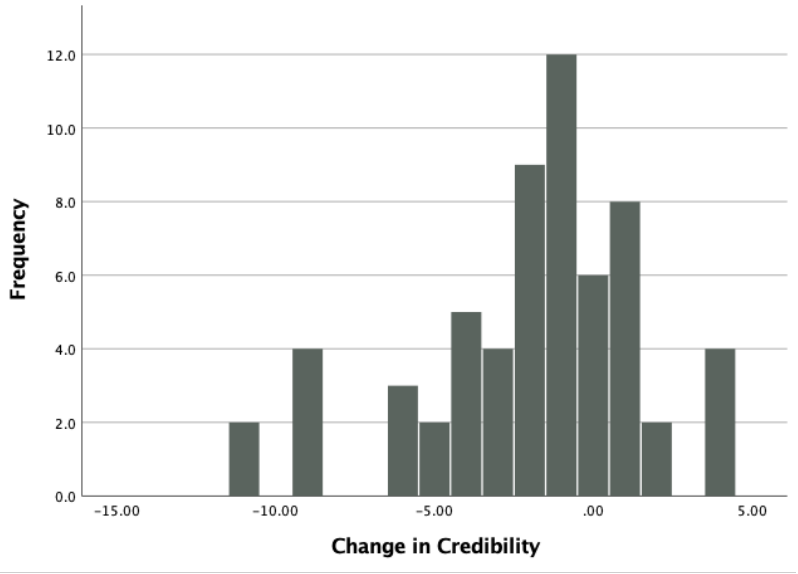


Figure R3

Change in Expectancy: Control Video

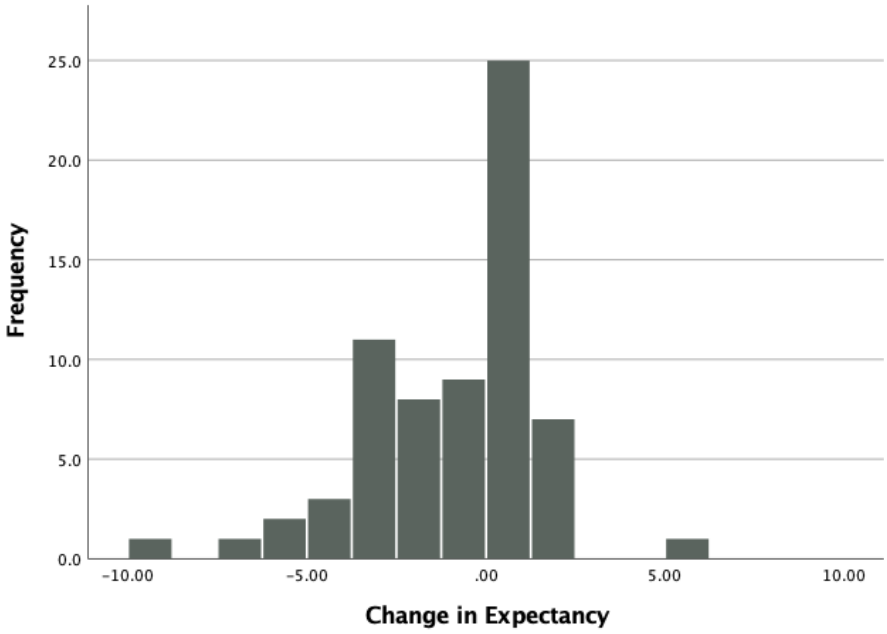
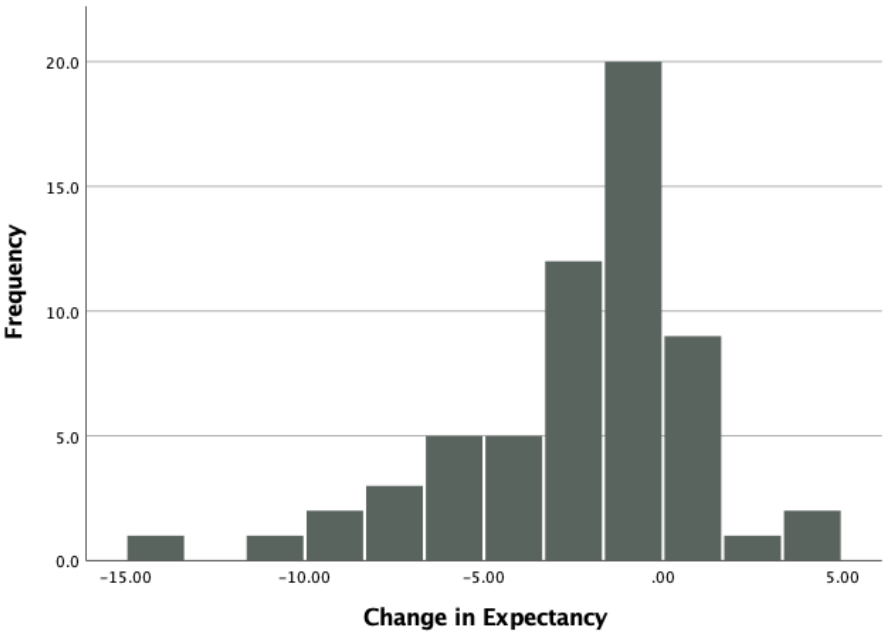


Figure R4

Change in Expectancy: Experimental Video



Appendix S: TDRP Author Guidelines

British Journal of Clinical Psychology

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

2. AIMS AND SCOPE

The *British Journal of Clinical Psychology* publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

- clinical and abnormal psychology featuring descriptive or experimental studies
- aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, read the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- Papers reporting original empirical investigations;
- Theoretical papers, provided that these are sufficiently related to empirical data;
- Review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

4. PREPARING THE SUBMISSION

Free Format Submission

British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

To submit, login at https://www.editorialmanager.com/bjcp/default.aspx and create a new submission. Follow the submission steps as required and submit the manuscript. If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered. Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters; The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (objectives/methods/results/conclusions);
- Up to seven keywords;
- Practitioner Points: Authors will need to provide no more than 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.