DOCTOR OF PHILOSOPHY

Correlates of Posttraumatic Growth Following a Myocardial Infarction: A Systematic Review AND The Lived Experience of Obsessive-Compulsive Disorder and Religiosity: An Interpretative Phenomenological Analysis

Hegarty, Gayle

Award date:
2020

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Correlates of Posttraumatic Growth Following a Myocardial Infarction: A Systematic Review

The Lived Experience of Obsessive-Compulsive Disorder and Religiosity: An Interpretative Phenomenological Analysis

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Submitted in part fulfilment of the Doctorate in Clinical Psychology, School of Psychology, Queen’s University Belfast

Supervisors: Dr Martin Dempster, Dr Lesley Storey, Dr Dave Rogers

November 2019
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Section 1: Correlates of Posttraumatic Growth Following a Myocardial Infarction: A Systematic Review.

Acknowledgements:

Thanks goes to Dr Elaine McCahey and Dr Dave Rogers for assistance in screening studies.
Abstract

Correlates of posttraumatic growth (PTG) have been examined in the area of health psychology previously, with much focus on aspects of personality, coping and social support. This systematic review aimed to examine correlates of PTG for those who have experienced a Myocardial Infarction (MI). Studies which met inclusion criteria were assessed for quality and reviewed. Results showed an inconsistent strength of associations between studies and so conclusions cannot be drawn. Possible reasons for these differences are discussed and recommendations for future research are suggested.

Keywords

Posttraumatic Growth; PTG; Myocardial Infarction; MI
Correlates of Posttraumatic Growth Following a Myocardial Infarction: a Systematic Review.

Ischaemic heart disease is the leading cause of global deaths (World Health Organization, 2018) and myocardial infarction is the most frequent manifestation of this disease. Myocardial infarction (MI) is a sudden and life-threatening event that can be experienced as traumatic (Allan & Sheidt, 1998). Indeed, survivors of MI have been shown to meet diagnostic criteria for Post-Traumatic Stress Disorder (Spindler and Pederson, 2005). Additionally, survivors of MI may experience depression or anxiety in response to their diagnosis, the uncertainty surrounding treatment and concern regarding further attacks (Eriksson, Asplund, Hochwalder & Svedlund, 2013).

Posttraumatic Growth (PTG) is the positive change experienced by individuals that emerges from the struggle following a life challenge or trauma that has impacted an individual’s assumptive world or core beliefs (Tedeschi & Calhoun, 1996). It refers to an enhancement or improvement in psychosocial functioning compared to the individual state before the key event. Initially coined as ‘perceived benefits’ (Colhoun & Tedeschi, 1990), the term PTG is now used to communicate the transformative experience which is reported by the individual and observed by those close to them (Blackie, Jayawickreme, Helzer, Forgeard & Roepke, 2015). The concept of PTG has emerged primarily from the study of trauma and how individuals adjust and cope with same. Tedeschi, Shakespeare-Finch, Taku and Colhoun (2018) assert this is a constructivist perspective, in that individuals experiencing life challenges will make individual versions of core beliefs and form assumptions based on this to inform their view of themselves, the world and their future. Janoff-Bulman (2004) describes this process of
adjustment as finding strength through trauma, psychological preparedness and existential re-evaluation through a search for meaning.

PTG has been identified across a range of health complaints, including serious medical conditions (Barskova & Oesterreich, 2009; Casellas-Grau, Ochoa, Ruini, 2017). A systematic review of qualitative studies that examined PTG in life-threatening physical conditions (Hefferon, Grealy & Mutrie, 2009) found overarching themes of reappraisal of life and priorities, trauma equalling development of self, existential evaluation and new awareness of the body. A systematic review of quantitative studies (Barskova & Oesterreich, 2009) found PTG in those who have a life-threatening disease across 68 studies covering HIV/Aids, cardiac disease, rheumatoid arthritis, multiple sclerosis, spinal cord injuries, orthopaedic injury, burns, lupus and also general disease (mixed study). Additionally, a study by Cordova, Cunningham, Carlson & Andrykowski (2001) compared two groups of age and education matched women. One group had been diagnosed with breast cancer, whilst the other was ‘healthy’. They found that whilst both groups had similar levels of wellbeing and distress, the women with breast cancer displayed PTG. Additionally, Powell, Elkin-Wood and Collin (2007) conducted a study which found PTG in survivors of brain injury (stroke and traumatic brain injury).

More specifically, PTG has been shown to occur in individuals who have experienced MI, with up to 65% of individuals reporting positive changes (Norekval et al. 2008; Petrie, Buick, Weinman & Booth, 1999). An influential study by Affleck, Tennen, Croog, & Levine, (1987) set out to examine predictors of reoccurrence of MI. This was a longitudinal study, interviewing 247 men at two time points; 7 weeks and 8 years after a myocardial infarction. Independent of physician’s ratings of prognosis and
sociodemographic levels, those who perceived benefits following an MI were less likely to experience a further MI.

There is evidence therefore that PTG occurs for some people after experiencing MI and that this can have beneficial outcomes. This leads to the question; why does this occur for some people, that is what factors might explain individual variations in the experience of PTG? Helgeson (2003) measured cognitive adaptation to cardiac events and discovered higher adaptation predicted lower numbers of cardiac events. Findings such as these lead us to consider which particular aspects of adaptation are associated with PTG and particularly in relation to MI?

Research has focussed on five areas; personality characteristics, cognitive processing, coping mechanisms, social support variables and mental health, which of course may have moderating and mediating effects on each other. Wider PTG research on personality has shown that extraversion correlated positively with PTG whilst neuroticism had no relationship (Tedeschi & Colhoun, 1996). In terms of how cognitive processing relates to PTG in health conditions, research suggests that perceptions relating to the events are important. For example, perceived intensity of disease (Bellizzi & Blank, 2006) was positively associated with PTG in patients being treated for breast cancer and in another study PTG was found to be positively associated with perceived life threat whilst unrelated to distress or wellbeing (Cordova et al. 2001). There is some evidence that social support is an important aspect of PTG with the aforementioned systematic review (Barskova & Oesterreich, 2009) finding a positive correlation. This has since been supported by further research (Nenova, DuHamel, Zemon, Rini & Redd, 2013; Sim, Lee, Kim & Kim, 2015). In addition, the review found coping strategies
positively associated with PTG. Finally, consideration of how anxiety or depression might interact with growth is crucial. A systematic review of PTG in cancer patients (Casellas-Grau, Ochoa, Ruini, 2017) examining psychological and clinical correlates of PTG in cancer found that PTG was inversely associated with anxiety and depression symptoms.

**Rationale and Aims of the Review**

The review aims to explore the correlates of PTG in individuals who have experienced MI. The use of psychological theory, knowledge and interventions within the physical health fields continues to grow and given the evidence of PTG in this area, it remains important for psychologists to know what predicates this growth. Not only is this important for intervening with the appropriate person to foster this growth; but it may be utilised in rehabilitation service design and planning. Therefore, the specific review question is: what are the factors associated with post-traumatic growth among people who have experienced a myocardial infarction and what is the strength of the association between these factors and post-traumatic growth?
Method

The review methods followed the PRISMA statement (Moher, Liberati, Tetzlaff, & Altman, 2009).

Inclusion and Exclusion Criteria

Studies were included if they examined correlates of PTG in individuals who had a diagnosed myocardial infarction. Studies which utilised a valid measure of PTG such as (but not confined to) the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996), Benefit Finding Scale (Tomich & Helgeson, 2002) and the Personal Growth Scale (Garnefski, Kraaij & Spinhoven, 2001), were accepted and correlates had to be examined using a valid psychometric tool. Studies not in English were excluded. Note that criteria were not set in relation to date of study, geographical location, demographics or research setting.

Search Strategy

Following initial scoping exercises to identify papers relating to predictors of PTG that included related terms such as STEMI and NSTEMI within the specific MI population, a search protocol was developed.

The protocol was registered with PROSPERO (International prospective register of systematic reviews: National Institute for Health Research) in November 2018, with the search taking place in January 2019. This can be viewed in Appendix 1.
Given that the review straddled medical, psychological and trauma research fields, suitable databases were identified. These were Web of Science, MEDLINE, Scopus, PILOTS and PsycINFO. The databases were searched using key terms (exploded and mapped to subject headings where appropriate); posttraumatic growth OR post-traumatic growth OR post traumatic growth OR benefit finding OR stress related growth AND myocardial infarction OR MI. The papers were saved in ‘RefWorks’ data management system and duplicates were removed. These papers’ titles and abstracts were then screened by GH and assigned into ‘keep’ or ‘discard’ categories and the former papers were appropriate for full text screening. GH and EM completed this step independently and discussed findings. In addition, a hand search of the references of each of the final papers was conducted to identify any further papers which met the inclusion criteria. No further papers were found.

The studies retained after full text assessment were evaluated for quality by GH and DR using the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (National Heart, Lung and Blood Institute, 2014). This is a 14-item measure with an overall poor, fair or good quality rating status. The tool requires the researcher to rate the papers according to the guidance and their own skilled judgement. Nine of the questions were relevant for these cross-sectional studies (see Appendix 2, Table 1) and so only these nine questions were used for quality assessment and the other questions were discarded. Questions deemed not applicable concerned repeated measures, differing levels of exposure and follow-up rates, which are all more suited to longitudinal studies rather than cross-sectional studies. Both GH and DR conducted their assessment independently.
Results

As evidenced in Figure 1, 115 papers were initially identified by database searches and no further papers from hand searches. Removal of duplicates reduced the papers to 86 and following screening of titles and abstracts eight papers were identified for full text evaluation. Figure 1 identifies the reasons why papers were rejected during the searches at these two points. Five papers met the inclusion criteria with full agreement amongst reviewers. Quality assessment rated one paper ‘good’, three ‘fair’ and one ‘poor’ (see Appendix 2, Table 1). Both reviewers discussed all ratings and reached complete agreement.

The studies scored well in terms of objectives, clearly defined populations, independent variables and outcome measures of Post Traumatic Growth (dependent variable). One study (Losiak & Nikiel, 2014) states the participants were taking part in cardiac rehabilitation but does not indicate the setting (hospital or community). However, it was considered that the population was likely to be similar in terms of referral to the rehabilitation group. There were variations in recruitment and time since MI in the study by Senol-Durak & Ayvasik (2010). Clarification was requested by email regarding this (see Appendix 3), but no response was received. Four of the studies administered the PTGI using self-report methods, whereas Javed & Dawood (2016) used interview methods to collect responses from the participants. This potentially introduces interviewer bias (Cook, 2010) and downgraded the paper’s quality assessment from ‘Good’ to ‘Fair’.
The data extraction table (see Table 2) summarizes the main elements such as study aim, design and measures. Most studies were carried out within hospital populations, using service databases to contact individuals diagnosed with MI (as discussed, with exception Losiak & Nikiel, 2014 which does not clearly state).
Figure 1: PRISMA Flowchart

**Identification**
- Records identified through database searching (n=115)
- Additional records identified through other sources (n=0)
- Records after duplicates removed (n=86)
  - Records excluded n=78, with reasons
    - Qualitative (n=7)
    - Not measuring correlates of PTG in patients following MI (n=65)
    - Not in English (n=3)
    - Examined spouses and not patients (n=3)

**Screening**
- Records screened (n=86)

**Eligibility**
- Full-text articles assessed for eligibility (n=8)
  - Full-text articles excluded n=3, with reasons
    - Not measuring correlates of PTG in patients following MI (n=2)
    - Intervention (n=1)

**Included**
- Studies included in narrative synthesis (n=5)
Not all studies stated explicitly that the participants had a confirmed diagnosis of MI, however all of the studies detailed the number of MI’s experienced by the participants, and therefore this was accepted as evidence of MI having occurred.

**Posttraumatic Growth Measure:** In all cases the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996), or an adapted version, was used to measure post-traumatic growth. The PTGI (Tedeschi & Colhoun, 1996) is an instrument developed to assess positive changes following a traumatic event. Internal consistency was originally reported as excellent (.90) by Tedeschi & Colhoun (1996), with two of the identified MI studies in this review reporting this higher at .95 (Senol-Durak & Ayvasik, 2010; Rahimi, Heidarzadeh & Shoae, 2016). Tedeschi & Calhoun (1996) also reported an acceptable test-retest reliability score (.71). The 21 item self-report measure uses a six-point Likert scale (0-5). Five factors are encompassed within the scale, which are denoted in brackets here with corresponding questions. They include ‘I changed my priorities about what is important in life’ (Appreciation of Life), I developed new interests (New Possibilities), I have a greater feeling of self-reliance’ (Personal Strength), ‘I have a better understanding of spiritual matters’ (Spiritual Change), and ‘I have a greater sense of closeness with others’ (Relating to Others). The Personal Growth Scale (Garnefski et al., 2008) is an adapted 5 item version of the PTGI. Only two aspects of the scale are included; ‘Appreciation of Life’ and ‘Personal Strength’. Garnefski (2008) points to the Principal Component Analysis confirming the one-dimensional structure of the scale and the reliability in the study was high (.90).
The correlates of PTG examined in the studies varied across the studies but included coping (in 4 studies), social support (in 3 studies), personality (in 2 studies) and psychological health (in 1 study).
<table>
<thead>
<tr>
<th>Reference</th>
<th>Sample Details</th>
<th>Inclusion &amp; Exclusion Criteria</th>
<th>Design</th>
<th>PTG Measure</th>
<th>Predictor/ Correlate Measure</th>
</tr>
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<tbody>
<tr>
<td>Study 1: Garnefski, Kraaij, Shroevers &amp; Somsen, 2008</td>
<td>Netherlands, one medical centre, n=139 (246 eligible from database), outpatients in cardiology clinic, male and female, range 35-70 years, information and consent via phone</td>
<td>Inclusion criteria: Over age 30 and under age 70 years, 1st time MI, length of time from MI 3-12 months, all had intervention of PCI (3-12 months also).</td>
<td>Cross sectional</td>
<td>Personal Growth Scale adapted elements of PTGI.</td>
<td>Personality (NEO-FFI), psychological health (HADS, WHO-5) cognitive coping (CERQ)</td>
</tr>
<tr>
<td>Study 2: Javed &amp; Dawood, 2016</td>
<td>Pakistan, 4 different hospitals, n=90, male &amp; female. 45-65 years, 1st MI, Purposive sampling</td>
<td>Inclusion criteria: 45-65 years, 1-36 months since MI. First MI. Exclusion Criteria: No hope for recovery, major surgery after MI, other physical illnesses (except diabetes and hypertension), diagnosis of CVD before MI and diagnosed psychiatric illnesses at point of data collection.</td>
<td>Cross-sectional</td>
<td>PTGI</td>
<td>Personality traits (BFI), perceived social support (MSPSS), coping strategies (Brief COPE) Urdu versions of all.</td>
</tr>
<tr>
<td>Study 3: Losiak &amp; Nikiel, 2014</td>
<td>Poland, myocardial infarction patients undergoing cardiological rehabilitation following MI, setting not stated, n=53, range 39-68 years, male and female, 1st MI, 1.5-19 weeks prior</td>
<td>Not stated</td>
<td>Cross sectional</td>
<td>PTGI (polish version with four factors)</td>
<td>Cognitive coping (CERQ)</td>
</tr>
</tbody>
</table>
Table 2 (continued)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Sample Details</th>
<th>Inclusion &amp; Exclusion Criteria</th>
<th>Design</th>
<th>PTG Measure</th>
<th>Predictor/ Correlate Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 4: Rahimi, Heidarzadeh &amp; Shoaei, 2016</td>
<td>Iran, 1 hospital’s cardiac clinic, n=166 (out of 188 eligible), range 21-90 years, male &amp; female, 3-12 months since MI</td>
<td>Inclusion criteria: Min age 21, definite diagnosis of MI, consent, power to communicate, at least 3 months since attack. Exclusion criteria: Severe psychological disorders or Alzheimer’s.</td>
<td>Cross-sectional</td>
<td>PTGI</td>
<td>Social Support (CSSS)</td>
</tr>
<tr>
<td>Study 5: Senol-Durak &amp; Ayvasik, 2010</td>
<td>Turkey, 4 state hospitals, n=148, (188 asked and 36 declined), 4 excluded after data collection, range 27-80 years, male and female, mini telephone interview and then face to face. Between 1-4 MI events, range 2-25920 days since diagnosis.</td>
<td>Excluded if had other life-threatening illness in self, spouse, or child.</td>
<td>Cross-sectional</td>
<td>PTGI</td>
<td>Perceived social support (MSPSS) and coping (WCQ with 8 more items added to Turkish version).</td>
</tr>
</tbody>
</table>

Note: PCI percutaneous coronary intervention, PTGI Posttraumatic Growth Inventory, NEO-FFI Neuroticism Extraversion Openness-Five Factor Inventory, HADS Hospital Anxiety & Depression Scale, WHO-5 Wellbeing Questionnaire, CERQ Cognitive Emotion Regulation Questionnaire, BFI Big Five Inventory, MSPSS Multidimensional Scale of Perceived Social Support, CERQ Cognitive Emotion Regulation Questionnaire, CSSS Clinical Social Support Scale, WCQ Ways of Coping Questionnaire.
### Table 3. Correlation coefficient of PTG and factors

<table>
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<tr>
<th>Factor</th>
<th>Subscale (Instrument)</th>
<th>r (n)</th>
<th>Reference</th>
</tr>
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<tr>
<td>Coping</td>
<td>Problem focused coping (WCQ)</td>
<td>.21 (148)</td>
<td>Senol-Durak &amp; Ayvasik (2010)</td>
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<tr>
<td></td>
<td>Problem focused coping (Brief COPE)</td>
<td>.90 (90)</td>
<td>Javed &amp; Dawood (2016)</td>
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<td></td>
<td>Emotion focused coping (WCQ)</td>
<td>.34 (148)</td>
<td>Senol-Durak &amp; Ayvasik (2010)</td>
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<tr>
<td></td>
<td>Active emotional coping (Brief COPE)</td>
<td>.85 (90)</td>
<td>Javed &amp; Dawood (2016)</td>
</tr>
<tr>
<td></td>
<td>Avoidant emotional coping (Brief COPE)</td>
<td>-.83 (90)</td>
<td>Javed &amp; Dawood (2016)</td>
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<td></td>
<td>Indirect coping (WCQ)</td>
<td>-.35 (148)</td>
<td>Senol-Durak &amp; Ayvasik (2010)</td>
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<td></td>
<td>Cognitive coping total (CERQ)</td>
<td>.57 (53)</td>
<td>Losiak &amp; Nikiel (2014)</td>
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<td></td>
<td>Self-blame (CERQ)</td>
<td>.03 (139)</td>
<td>Garnefski, Kraaij, Shroevers &amp; Somse (2008)</td>
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<td>Acceptance (CERQ)</td>
<td>.07 (139)</td>
<td>Garnefski, Kraaij, Shroevers &amp; Somse (2008)</td>
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<td>Rumination (CERQ)</td>
<td>.03 (139)</td>
<td>Garnefski, Kraaij, Shroevers &amp; Somse (2008)</td>
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<th>Coping</th>
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<td>Positive refocusing (CERQ)</td>
<td>.22 (139)</td>
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<td>Planning (CERQ)</td>
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<td>Positive reappraisal (CERQ)</td>
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<td>Putting into perspective (CERQ)</td>
<td>.22 (139)</td>
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<td>Catastrophizing (CERQ)</td>
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<td>Other-blame (CERQ)</td>
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<td>Social support total (CSSS)</td>
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<td>Emotional dimension (CSSS)</td>
<td>.35 (166)</td>
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<th>Perceived social support total (MSPSS)</th>
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<tr>
<td></td>
<td>.91 (90)</td>
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<td>.11 (148)</td>
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<th>Agreeableness (BFI)</th>
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<td>.09 (139)</td>
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<td>.73 (90)</td>
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<th>Personality (continued)</th>
<th>Conscientiousness (NEO-FFI)</th>
<th>.34 (139)</th>
<th>Garnefski, Kraaij, Shroevers &amp; Somse (2008)</th>
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</thead>
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<tr>
<td>Neuroticism (BFI)</td>
<td>-.81 (90)</td>
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<tr>
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<td>Openness to experience (BFI)</td>
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<table>
<thead>
<tr>
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<th>Depression (HADS)</th>
<th>-.39 (139)</th>
<th>Garnefski, Kraaij, Shroevers &amp; Somse (2008)</th>
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</thead>
</table>

Note: NEO-FFI Neuroticism Extraversion Openness-Five Factor Inventory, HADS Hospital Anxiety & Depression Scale, WHO-5 Wellbeing Questionnaire, CERQ Cognitive Emotion Regulation Questionnaire, BFI Big Five Inventory, MSPSS Multidimensional Scale of Perceived Social Support, CERQ Cognitive Emotion Regulation Questionnaire, CSSS Clinical Social Support Scale, WCQ Ways of Coping Questionnaire.
Table 3 shows correlation coefficients of PTG and the factors examined in the five studies. Results show that the correlation coefficients are often limited to one study or are not consistent across studies and therefore findings are inconclusive.

**Coping.** Four studies examined the role of coping in PTG (Garnefski, Kraaij, Shroovers & Somsen, 2008; Senol-Durak & Ayvsik, 2010; Losiak & Nikiel, 2014; Javed & Dawood, 2016). Two studies (Garnefski et al., 2008; Losiak & Nikiel, 2014) used the Cognitive Emotion Regulating Questionnaire (CERQ; Garnefski, Kraaj & Spindhoven, 2001) however only Losiak & Nikiel (2014) found a strong positive relationship to exist. Garnefski et al., (2001) did not report the total CERQ correlation, but rather the subscales. These overall found a weak to moderate association with PTG.

Two studies examined problem focussed coping. Javed & Dawood (2016) used the Brief COPE (Carver, 1997) and Senol-Durak & Ayvasik (2010) administered the Ways of Coping Questionnaire (Folkman & Lazarus, 1988) and whilst both found a positive association these varied from weak to strong and therefore are not consistent. Indeed, the study conducted by Javed & Dawood (2016) had the strongest association between coping and PTG on all subscales. However, the strength of these findings was not supported by the other three studies.

**Social Support.** Three of the studies (Senol-Durak & Ayvasik, 2010; Javed & Dawood, 2016; and Rahimi et al, 2016) addressed the area of social support and PTG. Whilst all studies found a positive association between the variables, the strength of this relationship varied, and it was difficult to directly compare the data between studies. Both Javed & Dawood (2016) and Senol-Durak & Ayvasik (2010) examined perceived
social support using the same self-report measure (Multidimensional Scale of Perceived Social Support; Zimet, Dahlem, Zimet & Farley, 1988); however, one reported subscale coefficients and the other presented total scale association. There was a marked difference in the strength of association, with Senol-Durak & Ayvasik (2010) finding a weak positive association and Javed & Dawood (2016) reporting a strong positive relationship between the variables.

**Personality.** Two studies examined the relationship between personality and PTG (Garnefski et al., 2008; Javed & Dawood, 2016) and used the Neuroticism Extraversion Openness-Five Factor Inventory (Costa & McCrae, 2004) and Big Five Inventory (John & Srivastava, 1999) scales respectively to measure these constructs. Whilst different self-report measures were administered, they both contained the same five subscales of extraversion, agreeableness, conscientiousness, neuroticism and openness to experience and are therefore comparable. Table 3 shows that whilst the study by Javed & Dawood (2016) reported moderate to strong associations between the subscales and PTG, Garnefski et al. (2008) found mainly weak to negligible associations. For example, Javed and Dawood (2016) found neuroticism to be strongly negatively associated with PTG ($r=-.81$, $n=90$), with Garnefski et al. (2008) reporting a weak negative relationship ($r=-.22$, $n=139$). In fact, Javed & Dawood (2016) reported a strong correlation with all aspects of personality, presenting a strong positive relationship with extraversion, agreeableness, conscientiousness and openness to experience and a strong negative relationship with neuroticism. So, despite comparable psychometric measures, results are inconsistent.
Psychological Health. One study examined the relationship of psychological health and PTG (Garnefski et al., 2008). The measures to determine psychological health were the Hospital Anxiety and Depression Scale (HADS: Snaith, 2003) and the WHO-5 Well-being Questionnaire (Bech, 1998). A decision to only use the depression subscale from the HADS (Snaith, 2003) was made without adequate explanation. Therefore, the anxiety subscale was not used. A moderate negative correlation between PTG and depression was found and a moderate positive correlation with positive wellbeing. Given that these variables and results feature in only one study, no definitive conclusions can be drawn within the review.

Discussion

This review aimed to determine the factors associated with post-traumatic growth among people who have experienced a myocardial infarction and the strength of the association between these factors and post-traumatic growth. The five papers that met inclusion criteria examined four factors; coping, social support (and perception of), personality and psychological wellbeing. Results showed inconsistent strength of associations across all four variables so no conclusions regarding the relationship between these variables and PTG can be drawn. It is important to examine why this may be the case, in the context of this health condition in relation to wider health and PTG literature and factors which may be impacting such as type of study design, methodology and study quality.

The role of personality in how individuals experience PTG has already been highlighted. Tedeschi & Colhoun (1996) found that extraversion was most likely to
correlate with PTG and neuroticism was not associated with growth. These findings were corroborated by Sheikh (2004) in the context of heart disease patients in UK and USA. The study by Garnefski et al. (2008) followed this pattern of findings but, contrary to previous research, another study found extraversion to be strongly positively correlated with PTG, but neuroticism was strongly negatively correlated with PTG (Javed & Dawood, 2016). There were also differences between the studies in the strength of the positive relationship.

These findings could be related to several differences between the studies. The research teams used different PTG and personality measures and there were differences in homogeneity of the study populations. Garnefski et al. (2008) only examined those who had percutaneous coronary intervention (PCI) and limited their participants to 3-12 months after this point. Javed & Dawood (2016) did not address whether participants had a medical procedure such as a PCI and they examined participants 1-36 months from MI diagnosis. The impact of a procedure such as a PCI might influence views on ‘New Possibilities’ or ‘Appreciation of Life’ as measured in the PTGI (Tedeschi & Calhoun, 1996). This in turn could influence coping and perceived support, which in turn could affect growth levels. Therefore, a difference in participant experiences may account for this disparity in association.

Cultural differences across the studies are also conceivable. Each of the five studies were conducted in different countries. Whilst we are aware that PTG as a phenomenon occurs globally (Weiss & Berger, 2010; Sawyers, Ayers & Field, 2010), studies have also shown differences, such as higher levels of PTG in the USA compared to much lower levels in Japan (Taku, 2010). Researchers have hypothesised that some
societies (such as the USA) promote self-enhancement and there is a societal pressure to report growth (Zoellner, Rabe, Karl, & Maercker, 2008).

Tedeschi et al. (2018) are keen to point out differences in individualistic and collective norms within society, which influence how individuals attach meaning to and respond to trauma. Moreover, the studies all used a translated version of the original PTGI (Tedeschi & Colhoun, 1996). One study (Garnefski et al., 2008) used an adapted version, whilst another (Losiak & Nikiel, 2014) found validity in a four-factor version of the scale when translated into Polish. It is unclear how these differences have impacted on associations and the comparisons of such across the five studies.

Following on from this point, it is worth considering differences in health-care systems across the studies. None of the studies took place in the United Kingdom, where referral to non-governmental organisations (such as The Chest, Heart and Stroke Association) for rehabilitation is standard practice and it may be protocol for MI survivors in other countries to be referred to health service, community support and rehabilitation groups. None of the studies recorded participant involvement with such support and yet research shows how informational and social support increases PTG (Nenova et al; 2013; Sim et al., 2015).

In addition, the way in which individuals’ access health-care may be dissimilar and there may be differences in how health information is communicated either individually by practitioners, or systemically. These aspects, along with individual, societal or cultural norms are likely to lead to variances in associations which are not easily identified across the studies.
Whilst several of the studies controlled for previous MI events, psychiatric or physical illness and major surgery; none appeared to consider impact of previous trauma. This appears to be a deficit across other research studies, as highlighted by Bostock, Sheikh & Barton (2009) in a systematic review of health-related trauma. Given that assumptive core beliefs are an integral part of PTG and the individual’s subsequent adaptation to the event (Tedeschi & Colhoun, 1996), their trauma history will undoubtedly have an impact on their world view. MI is a sudden threat to life, and the theory of PTG incorporates the psychological reaction to this, so the occurrence of more than one of these events will increase the trauma burden for said individuals. It is likely that this would impact on PTG. Whilst recruiting from a more heterogeneous group has ecological validity, results are likely to be affected by these successive traumas.

Following this theme, there were differences in numbers of MI experienced. In one of the studies individuals had experienced between one and four MI’s. Three of the other studies included only those who had experienced their first MI whilst Rahimi et al. (2016) did not disclose this statistic. If MI is to be considered a traumatic event, and the literature supports this hypothesis, the number of MI’s experienced should be considered within the research. This may impact on how an individual adjusts to their trauma, their PTG and factors such as psychological wellbeing and coping.

Study quality should be considered. The quality evaluation tool was designed for cross-sectional studies, and the assessment concluded that one of the studies was good, three were fair and one was weak. This may have contributed to discrepancies in the findings across the studies. For example, a ‘fair’ (Javed & Dawood, 2016) and ‘weak’ (Senol-Durak & Ayvasik, 2010) study examined perceived social support using the
same scale but reported strong and weak positive associations respectively. Whilst the Senol-Durak (2010) study met inclusion criteria, its methodology lacked rigour, and vital elements such as time from MI or number of MI’s experienced, were not considered. The Javed & Dawood (2016) study presented strong correlations and scored highly on all aspects of quality except mode of data collection, which involved interviewing participants using the PTGI (Tedeschi & Calhoun, 1996) as opposed to allowing participants to self-report. Cook (2010) highlights the risk of interviewer bias in obtaining preferred responses to questions. The Javed & Dawood (2016) study stood out in terms of its results and it is possible that mode of data collection is a confounding variable, with potential impact on results.

The PTGI’s test-retest reliability does not specifically refer to the MI population but as previously discussed Tedeschi & Colhoun (1996) found it was at an acceptable level (.71). It is noted that the correlation coefficient scores on most construct relationships within the Javed & Dawood (2016) study are higher than this test-retest reliability. This seems unusual and adds to concern over study quality. Whilst the quality assessment tool used did not assess this aspect, these high correlation figures raise further questions over the quality of the Javed & Dawood (2016) study.

It is noted that the studies differed in time from when the MI occurred. Whilst two studies (Rahimi et al., 2016: Garnefski et al, 2008) conducted their studies 3 to 12 months after MI, Javed and Dawood’s (2016) study spanned 1 to 36 months. The study by Senol-Durak & Ayvasik (2010) recorded time from MI as being between 2 and 25920 days (which is over 71 years). Therefore, the question of what was being measured arises. Bostock et al. (2009) in a systematic review of PTG and optimism in
health-related trauma, points out that time must elapse to allow growth to develop, but that general literature does not stipulate optimum timescales involved. It does appear that there is no defined course of PTG development. For example, Stanton, Bower & Low (2006) state that PTG appears to be higher in the year or two following an event but may then diminish. Therefore, time from event should be considered in study design as variations can make it difficult to draw comparisons between studies.

It is also important, particularly given the inconclusive nature of the review, to consider Post Traumatic Growth as a construct in itself. For example, the assertion that trauma is required for this growth is challenged by Aldwin and Levenson (2004), who point out that the birth of a child often precipitates changes in parental outlook and values and yet is not categorized (generally) as a trauma. Certainly, there are other terms and constructs which also communicate positivity or benefits following an event or trauma. These include ‘benefit finding’, ‘stress-related growth’, ‘resilience’ or ‘adjustment’. The use of different psychometric measures to capture these experiences mean that a clear picture of how and why growth occurs, is still in its infancy. It appears that PTG and benefit finding are strongly associated with adjustment (Davis, Nolen-Hoeksema & Larson, 1998), but only when a longitudinal methodology is used. Park (2004) comments that the extent of the relationship between adjustment and growth is unclear, and that sophisticated research methods are required to examine these constructs. Lechner and Antoni (2004) posit that these different terms and constructs have different implications and as yet, we do not know where they overlap.

Limitations and future directions
Although this review was robust in its protocol and analysis there were a few limitations that should be highlighted. The small number of studies identified examined a narrow range of variables which can impact on PTG. For example, distress levels and anxiety (Barskova & Oesterreich, 2009), or illness perceptions (Leung, Gravelly-Witte, Macpherson & Irvine, 2010) were not included in these studies.

The protocol excluded studies that were not in English. These may have added to our review. All the studies examined were cross-sectional, and so causation and direction of influence cannot be extrapolated. A study using a longitudinal design would be valuable in examining measures at several time-points.

Future research should consider confounding variables such as time from diagnosis, number of MI’s experienced and other interventions (medical and social) that the population may have experienced. Longitudinal research specifically to ascertain PTG levels following MI would be extremely valuable. This could inform timing of interventions.

Conclusions

This is the first systematic review to examine the correlates of PTG in individuals who have experienced an MI, and the strength of such associations. The five cross-sectional studies addressed the association between PTG and social support, coping, psychological well-being and personality. The results showed an inconsistent pattern of association; therefore, conclusions cannot be drawn. Possible contributing factors such as study quality, previous trauma, cultural or methodological differences were highlighted. These findings have implications for future research, in that longitudinal studies which
take account of these confounding variables are recommended, so that direction of association can be extrapolated.
References


Section 2

PROSPERO protocol

**PROSPERO**

*International prospective register of systematic reviews*

Predictors of posttraumatic growth for individuals following a myocardial infarction

*Gayle Hegarty, Lesley Storey*

**Citation**

Gayle Hegarty, Lesley Storey. Predictors of posttraumatic growth for individuals following a myocardial infarction. PROSPERO 2018 CRD42018114482 Available from: http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018114482

**Review question**

What are the predictors of posttraumatic growth for individuals following a myocardial infarction?

**Searches**

The search will be conducted using the following electronic databases: PsycINFO, PILOTS, Web of Science, MEDLINE and Scopus. No date restriction will be applied to the search, but it will be limited to English language.

Databases will be searched using key terms (mapped to subject headings and exploded) of post traumatic growth OR posttraumatic growth OR post-traumatic growth OR PTG OR benefit finding OR stress related growth AND myocardial infarction OR MI

**Types of study to be included**

Quantitative studies which have met inclusion criteria and examine predictors of post traumatic growth in individuals who have had a myocardial infarction. Intervention studies, and qualitative studies will be excluded. Non-English studies will be excluded.
Condition or domain being studied

Posttraumatic Growth (PTG) in individuals who have experienced a myocardial infarction.

Participants/population

Inclusion:

Adults with a diagnosed Myocardial Infarction.

Intervention(s), exposure(s)

Quantitative studies (which reach population inclusion criteria) where participants undertook a valid measure

of Post Traumatic Growth such as (but not limited to) the Post Traumatic Growth Inventory, Benefit Finding

Scale, and the Personal Growth Scale. In addition, the hypothesised predictors are examined using a valid

psychometric tool.

Comparator(s)/control

Not applicable.

Context

Participants must have experienced a Myocardial Infarction, therefore settings may include formal and

community settings.

Main outcome(s)

Predictors of posttraumatic growth as measured by a valid psychometric tool.

Timing and effect measures

Additional outcome(s)

None.

Timing and effect measures

Data extraction (selection and coding)
Using the search methods, all papers identified will be collated. Inclusion and exclusion will be captured using a PRISMA flowchart. Initial screening of abstracts and then a more thorough screen using full text documents will then take place (GH). This shall be screened independently by a second reviewer. Any discrepancies will be discussed and collectively agreed upon. Cohen's Kappa statistic will be used to calculate inter-rater reliability. A data extraction table shall be used to record data from those papers deemed suitable.

Data to be extracted: Author(s), study design, number of participants, measure of Post Traumatic Growth used, measurement of predictor used.

Risk of bias (quality) assessment

The 'Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies' offers a method of evaluating quality of the studies, and this shall be conducted by the principal researcher. This shall be overseen by an independent researcher, with discrepancies discussed and agreed mutually.

https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools

Strategy for data synthesis

The quantitative data will be reported in table, figure and narrative format. A synthesis of the study methodology and design will be undertaken.

Analysis of subgroups or subsets

None.

Contact details for further information

Gayle Hegarty

ghegarty02@qub.ac.uk

Organisational affiliation of the review

Queen's University Belfast
Review team members and their organisational affiliations

Mrs Gayle Hegarty. Queen's University Belfast
Dr Lesley Storey. Queen's University Belfast

Anticipated or actual start date
01 November 2018

Anticipated completion date
30 September 2019

Funding sources/sponsors

Gayle Hegarty is completing this systematic review as part fulfillment for the research requirements of the Doctorate in Clinical Psychology training programme at Queen's University Belfast.

Conflicts of interest

Language
English

Page: 2 / 3 PROSPERO

International prospective register of systematic reviews

Country
Northern Ireland

Stage of review
Review_Ongoing

Subject index terms status
Subject indexing assigned by CRD

Subject index terms
Humans; Myocardial Infarction

Date of registration in PROSPERO
21 November 2018
Date of publication of this version
21 November 2018

Details of any existing review of the same topic by the same authors

Stage of review at time of this submission
The review has not started

**Stage Started Completed**

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Versions
21 November 2018

PROSPERO

This information has been provided by the named contact for this review. CRD has accepted this information in good faith and registered the review in PROSPERO. CRD bears no responsibility or liability for the content of this registration record, any associated files or external websites.
**Appendix 2**

**Table 1:** Showing results of Quality Assessment using Quality of Observational Cohort and Cross-Sectional Studies (NHLBI, 2014)

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Was the research question or objective clearly stated?</th>
<th>Was the study population clearly specified and defined?</th>
<th>Were all the subjects selected or recruited from the same or similar populations (including the same time period)?</th>
<th>Was a sample size justification, power description, or variance and effect estimates provided?</th>
<th>Was the timeframe sufficient so that one could reasonably expect to see an association between outcome and exposure if it existed?</th>
<th>Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?</th>
<th>Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?</th>
<th>Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure and outcome?</th>
<th>Quality Assessment of study</th>
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<td>Was the study population clearly specified and defined?</td>
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<td>Was a sample size justification, power description, or variance and effect estimates provided?</td>
<td>Was the timeframe sufficient so that one could reasonably expect to see an association between outcome and exposure if it existed?</td>
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</table>
Email to Authors Regarding Study

Fri 29/03, 16:28

emre@emresenoldurak.com;
emresenoldurak@gmail.com;
emresenoldurak@yahoo.com;
abelgin@metu.edu.tr

Dear Emre / Belgin,

I am a final year Doctorate student at Queen’s University Belfast. My supervisor is Dr Lesley Storey. I am currently undertaking a systematic review of Predictors of Posttraumatic Growth following a Myocardial Infarction. Included in this is your 2010 paper, published in the *Journal of Clinical Psychology in Medical Settings*. I am hoping to publish my review in the same journal.

This is a really interesting study, but I have two important question. The table 1 appears to show that the length of time in days since MI is between 2 days and 71 years (2-25920.0 days) Is this correct? Does this refer to their first MI or their most recent one? It seems a long time to have had an MI 71 years ago.

My second query is why did the team decide to use a self-devised scale for perception of event? I know that with word restrictions it can be difficult to include all of this information in a paper.

Any information or data regarding this would be most helpful.

Thank you so much.

Regards,

Gayle Hegarty

Trainee Clinical Psychologist

Queen’s University Belfast
Section 3

Instructions for Authors (no word limit on submissions)

Journal of Clinical Psychology in Medical Settings

General

In general, the journal follows the recommendations of the 2010 Publication Manual of the American Psychological Association (Sixth Edition), and it is suggested that contributors refer to this publication.

Manuscript Submission

Manuscripts, in English, should be submitted to the Editor via the Journal’s web-based online manuscript submission and peer-review system: http://jocs.edmgr.com. Inquiries regarding Journal policy and other such general topics should be sent to the Editor:

Ronald Brown
ronald.brown@univ.edu

• www.jocs.edmgr.com

Publication Policies

Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to Springer will be required before the manuscript can be accepted for publication. Authors will receive an electronic notification to transfer copyright of the article to Springer. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

Manuscript Style

Submit the original, including copies of all illustrations and tables.

Add continuous line numbering and page numbering to the manuscript.

Title Page

A title page is to be provided and should include

• the title of the article
• author’s name (no degrees)
• author’s affiliation
• and suggested running head

The affiliation should comprise

• the department
• institution (usually university or company)
• city
• and state (or nation)

and should be typed as a footnote to the author’s name. The suggested running head should be less than 80 characters (including spaces) and should comprise the article title or an abbreviated version thereof. For office purposes, the title page should include the complete mailing address, telephone number, and e-mail address of the one author designated to review proofs.
Abstract

• An abstract is to be provided, preferably no longer than 150 words.

Key Words

• A list of 4–5 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

References

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. References should include (in this order):

• last names and initials of all authors,
• year published
• title of article
• name of publication
• volume number
• and inclusive pages

The style and punctuation of the references should conform to strict APA style and follow guidelines of the Publication Manual of the American Psychological Association, Sixth Edition – illustrated by the following examples:

• Journal Article

• Book

• Contribution to a Book

Footnotes

• Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript numeral for citation in the text.

Illustration Style

• Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals. The captions for illustrations should be typed on a separate page. Photographs should be large, glossy prints, showing high contrast. Drawings should be prepared with India ink. Either the original drawings or good−quality photographic prints are acceptable. Artwork for each figure should be provided on a separate page. Identify figures with the author’s name and number of the illustration. Electronic artwork should be in the TIFF or EPS format (1200 dpi for line and 300 dpi for half−tones and gray−scale art). Color art should be in the CYMK color space.
Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should be typed on a separate page. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

Submission of Accepted Manuscripts

After a manuscript has been accepted for publication and after all revisions have been incorporated, a final manuscript should be submitted through the online submission system. The electronic file submitted must be the finalized version of the manuscript. The author may track the status of a submission via the online submission system at the time. At the proofreading stage, the author is solely responsible for ensuring the accuracy and correctness of the typeset article. It is not possible to make further corrections once the article has been published online.

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Section 4: The Lived Experience of OCD and Religiosity: an Interpretative Phenomenological Analysis.

Acknowledgements:

I would like to express appreciation to the individual participants who wanted to let us all know how they experience their faith and OCD. Thank-you.

Thanks to Dr Dave Rogers for your knowledge, positivity and on the ground support. To Dr Kevin Dyer who helped enormously as always.

Special thanks to Dr Lesley Storey for sharing her wisdom and love of qualitative research, and to Dr Martin Dempster for imparting strong guidance and instilling confidence.

Thanks to my parents for teaching me to care. Finally, to Gerard, Ellen, Philip and Emily. No matter what.
Abstract

This paper explores the idiographic nature and personal meaning that OCD and religiosity present. Ten detailed interviews were conducted with individuals diagnosed as having OCD who also identified as being religious (Christian). The interviews were analysed using an interpretative phenomenological analytical approach.

Northern Ireland has the highest church attending population within the United Kingdom and a qualitative study into the lived experience of Obsessive-Compulsive Disorder (OCD) and religiosity had never previously been conducted here. Given the unique population in Northern Ireland, and its levels of church attendance, this study offers an insight into this disorder in this place. Themes of OCD and faith intertwined, OCD impacting internal and open faith practice, and OCD blocking connection to God were identified. The interconnection conceptually, through behaviour and belief is discussed, with implications for assessment, formulation and intervention in clinical practice and future research.

Keywords: Obsessive-Compulsive Disorder; religiosity; faith; interpretative phenomenological analysis
The Lived Experience of OCD and Religiosity: An Interpretative Phenomenological Analysis

**Obsessive-Compulsive Disorder**

Obsessive-Compulsive Disorder (OCD) is a condition with lifetime prevalence in approximately 1.1% of the U.K. population (Torres et al., 2006). High levels of co-morbidity have been found, primarily depression, anxiety disorders and tics. Traditionally viewed as an anxiety-based disorder, OCD now joins body dysmorphic disorder, hoarding disorder, trichotillomania and skin picking disorder in a category named “OCD and related disorders” (American Psychiatric Association, 2013). OCD is demarcated primarily by the existence of strong obsessions and/or compulsions within an individual. Obsessions are defined as recurrent, persistent thoughts, impulses or images that are unwanted, and cause distress. The individual attempts to ignore, suppress or neutralize the distressing thoughts with other repetitive thoughts or actions, which are known as compulsions. Compulsions are characterized by the individual feeling driven to perform them, and often rules are applied to the tasks (American Psychiatric Association, 2013; Menzies & de Silva, 2003; Wells, 1997). Examples of obsessions are fear of contamination, concern for harming self or others, or religious intrusions. Examples of compulsive behaviours are disproportionate checking, washing or mental compulsions such as counting or praying (Abramowitz, Deacon, Woods & Tolin, 2004; Foa & Kozak, 1995).

The Cognitive Behavioural model of OCD centres round the misinterpretation of intrusive thoughts and crucially the inflated responsibility felt by individuals for these thoughts (Salkovskis, Shafran, Rachman & Freeston, 1999). Whilst research suggests 80-90% of the population experience intrusive thoughts
(Rachman, 1998; Salkovskis, 1999), an individual who misinterprets these thoughts as posing a danger to self or others, and feels responsible in some way, is likely to have increased levels of anxiety. Studies by researchers in this area have found great validity in the cognitive model and have captured the six main characteristics of OCD in a published article (Obsessive – Compulsive Cognitions Working Group; 1997, 2001). These are inflated responsibility, beliefs about the importance of thoughts, beliefs about the importance of controlling one’s thoughts, overestimation of threat, intolerance of uncertainty and perfectionism.

The cognitive model suggests that these main cognitions, misinterpretation of intrusions and a sense of responsibility causes intense discomfort for the individual, leading to a need to relieve or reduce the unease through neutralising behaviours. These behaviours are used to avoid or dilute the distress; for example, suppressing thoughts or seeking reassurance helps to share the responsibility, and saying prayers or thinking good thoughts are seen as restitution or putting right (Rachman, 1971; Salkovskis & Westbrook, 1989). Unfortunately, neutralising behaviours increase perceived responsibility and attentional biases, which in turn leaves the individual more susceptible to misinterpretation of future intrusive thoughts. A vicious and distressing cycle is set in motion.

**Religiosity and Religious OCD**

It is important to draw a distinction between these two terms. As our understanding of OCD increases, so does our desire to consider the psychosocial variables that influence its development and treatment. Religiosity is one such variable and is the focus for this study. Connections between religious faith and OCD have been recounted as far back as the 16th century (Greenberg, Witzum &
Pisante, 1987). The study adopted the definition of religiosity as an individual’s conviction, devotion and veneration towards a divinity (Gallagher & Tierney, 2013). Typical religious practice is normally associated with a level of satisfaction and positive emotions whereas more compulsive rituals are associated with anxiety and fear (Greenberg & Shefler, 2008). By contrast to religiosity, ‘scrupulosity’ has been used to describe an individual’s focus on religious and moral fears, with a drive towards religious and moral perfectionism (Ciarrocchi, 1995); often referred to as ‘religious OCD’. It is important to note that whilst some literature may refer to ‘religious OCD’, it is not identified by the International classification of diseases for mortality and morbidity statistics (11th Revision; World Health Organization, 2018) or the Diagnostic and Statistical Manual of Mental Disorders -5 (American Psychiatric Association, 2013). In fact, subtypes are not identified within these frameworks at all. Williams, Mugno, Franklin and Faber (2013) discuss how OCD symptomology can be divided up into four dimensions of contamination/cleaning, doubting/checking, symmetry/ordering and unacceptable/taboo thoughts. ‘Religious OCD’ could be associated to a greater or lesser extent across all of these dimensions but again it is not identified as a separate subtype. Indeed, Tek & Ulug (2001) found no association between religiosity and OCD psychopathology but did observe that ‘religious OCD’ rarely presented as a singular obsession. They noted that rather than religion being causal in OCD, it appeared to be one more arena that OCD chose to express itself.

Religiosity and obsessional traits have been shown to be positively related with a greater level of OCD cognitions in those who were more religious (Inozu, Karanci & Clark, 2012; Yorulmaz, Gençöz & Woody, 2009). Another study found that where an individual had both religiosity and OCD, the levels are likely to match,
that is high religiosity is more likely in conjunction with higher levels of OCD (Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002; Abramowitz et al., 2004; Sica, Novara, & Sanavio, 2002; Steketee, Quay & White, 1991).

Whilst there appears to be more research cited suggesting that religious individuals are more likely to have OCD cognitions, it does not define these as ‘religious’ OCD cognitions but rather as ‘greater obsessional symptoms, compulsive washing and beliefs about the importance of thoughts’ (Abramowitz, 2004). This is important to consider. The literature also seems to show that it can be difficult to distinguish between religiosity and ‘religious OCD’ at times, due to conventional religious belief and practice (Abramowitz & Jacoby, 2014), and that the positive correlation between religiosity and OCD does not infer causality but may in fact be related to an individual’s experiences or personality making them more likely to be religious and have OCD (Abramowitz, 2004; Himle, Chatters, Taylor & Nguyen, 2013). All of these factors draw us to conclude that the study of the relationship between religiosity and OCD, is more appropriate than the narrower construct of ‘religious OCD’. This study is distinctive in that it harnesses this wider view and sets out to examine qualitatively how religiosity and OCD are experienced and any interaction between the two.

**Christianity and OCD**

The facets of religiosity and OCD fit together well in terms of the main cognitive characteristics already described and Christian faith in particular. Five of these are highlighted by Himle et al., (2013) and Abramowitz et al. (2004). Faith based interpretations may lead to ‘inflated responsibility’ and a need to reduce subsequent distress through neutralising safety behaviours. These may be faith-
based behaviours such as prayer, or service; or may take the form of more general (less faith-based) OCD type behaviours such as checking, hand-washing etc. Abramowitz et al. (2004) found that highly religious Protestants were more likely to have obsessional symptoms, beliefs about the ‘importance of thoughts’ and an ‘inflated responsibility’ compared to less religious Protestants or atheists.

The prevalence of ‘thought control/ suppression’ as well as restitution within religious faith closely matches Salkovskis’ (1999) model of OCD. Thought Action Fusion (or Thought Event Fusion) readily links with the Christian faith through its doctrine. The New Testament Sermon on the Mount (Matthew 5, 21-22, & 28) teaches:

‘I tell you that anyone who is so much as angry with a brother or sister is guilty of murder’

‘Who-ever looks on a woman to lust after her has committed adultery with her already in his heart.’

The inference is that a thought carries the same weight as the real action or event, and therefore intrusive thoughts which are contrary to religious teaching are likely to cause discomfort and distress. Williams, Lau & Grisham (2013) examined how Thought Action Fusion (TAF) mediated religiosity and OCD symptoms and found that teachings within faiths can fuel TAF beliefs. They found that teachings underlying Christian (but not Jewish) doctrines fuelled Thought Action Fusion beliefs, which helps to maintain OCD.

‘Intolerance of uncertainty’ also pervades religiosity, with religious OCD sufferers seeking reassurance from clergy and family, often causing relationship
strains and fractures (Calvocoressi et al., 1995; Himle et al., 2013). Finally, an ‘overestimation of threat’ can be seen where individuals become concerned that they will lose their salvation due to their thoughts, and their internal/external response to them (Himle et al., 2013).

Essentially, the above research suggests a certain congruence between the defining cognitions present in Christian religiosity and OCD. This perhaps presents a bleak picture, showing how it may be difficult to differentiate between when religious values and behaviours are healthy, or being driven more by OCD, especially since their basis lies in conventional religious belief and practice’ (Abramowitz & Jacoby, 2014). However, Himle et al. (2013) details how Exposure Response Prevention (ERP) and Cognitive Behaviour Therapy can be used to assist recovery, as well as the role of clergy. In addition, Abramowitz et al. (2004) found that highly religious Protestants with OCD were less likely to experience depression and suggests that religiosity may be a protective factor within an individual’s view of the world, self and future. Indeed, the very nature of religious practice requiring attendance at worship may reduce isolation and hence lower depression levels.

**Context and Rationale**

The study of religiosity and OCD has been mainly quantitative, focussing on a narrower construct of ‘religious OCD’, with no idiographic knowledge base depicting themes within the Christian faith. Coyle (2008) advocates the role of qualitative approaches in relation to religion and spirituality, as quantitative research is more reductionist in nature, whilst qualitative methods encourage ‘meaning making on their own terms’ (p4, pp2). Coyle (2008) also posits that the ineffable
nature of religiosity can make it difficult to put into words, underpinning the importance of the researcher’s interpretation.

Furthermore, research suggests a reluctance amongst practitioners to address faith issues (Hathaway, Scott & Garver, 2004). Indeed, this may be hampered by clinician concern, as Jackson and Coyle (2009) performed an Interpretative Phenomenological Analysis (IPA) of clinicians working with spiritual difference and found most ethical conflict arose when practitioners felt that clients’ views were not conducive to psychological well-being.

The Northern Ireland situation is unique in the UK context. The education system ranges from faith based to non-denomination but Christian in ethos. A high percentage of the population regard themselves as Christian (79%; ARK, 2018), compared to the rest of the UK which has been measured at 38% (Phillips, Curtice, Phillips & Perry, 2018). Northern Ireland’s church-going levels (and therefore potential or probable religiosity) are high at 33% (at least weekly), which is three times the UK average including other faiths. (Phillips et al., 2018). In addition, the ‘Northern Ireland Life and Times Survey’ found that 58% of people surveyed viewed themselves to be somewhat or very religious. The survey also found that 58% said religion was somewhat or very important in their everyday life (ARK, 2008).

Lewis and Joseph (1994) examined various personality traits in a Northern Irish population of students and found high levels of obsessional traits in students who were more religious. However, this study did not examine those who were diagnosed with OCD or OCD symptomology. Whilst the Lewis and Joseph (1994) study is relevant for the Northern Ireland population the examination of ‘traits’ is
less relevant for this particular study. Anxiety disorders (OCD included in this category) are estimated to impact upon 14.6% to 22.6% of the Northern Ireland population (Mental Health Foundation, 2016; Bunting, Murphy, O’Neill, & Ferry, 2012) with OCD measured in only one study at 0.5% lifetime prevalence (Bunting et al., 2012).

Given the cultural context of Northern Ireland with a high rate of church-going behaviours, therapeutic interventions must consider the role of religiosity, particularly as research shows the positive correlation between religiosity and OCD type cognitions. As aforementioned, Jackson and Coyle (2009) reported the reluctance of practitioners to discuss religious beliefs. This research took place in England. Given the context of religious difference in Northern Ireland one can hypothesise that discussing faith issues might be more difficult for both clinician and client. And yet practice guidelines advise psychologists to consider how clients’ spiritual beliefs might be detrimental to themselves and others or might be beneficial to wellbeing and incorporated into interventions (British Psychological Society, 2017).

The importance of examining the lived experience of OCD within this rich seam of church-going population is evident. An idiographic method such as Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) is viewed as a vital first step to truly hear the individual voice and draw overarching themes and general trends from the interviews. This will add to the knowledge base for clinicians working in the area, informing assessment and formulation practice. In turn this may influence the design and implementation of effective interventions.
Taking the available literature into account and the evident rationale for this study the research question asks:

What is the lived experience of Obsessive-Compulsive Disorder and religiosity?

Method

Participants

Ten participants were recruited, as it was felt that this number was achievable within the service, and it fell within guidelines from Smith, Flowers and Larkin (2009) that 6-12 participants is an optimum IPA subject number. All participants were over 18 years and residents of Northern Ireland. All were attending a Health Trust Psychological Therapies Service (PTS). This is a secondary care service for outpatient adult mental health offering a range of talking therapies. Obsessive Compulsive Disorder was their primary presenting condition (as defined by the clinician). Christian participants were defined in the inclusion criteria for three reasons. Firstly, for group homogeneity as desired in IPA (Smith et al, 2009), secondly Christianity is the most common faith in Northern Ireland at approximately 83% (Northern Ireland Statistics and Research Agency Census, 2011) and finally as research shows differences in how OCD and religiosity present across faiths (Yorulmaz, Gençöz, & Woody, 2009; Williams, Lau & Grisham, 2013).

The study wished to address the lived experience of religious individuals with all types of OCD. Given that previous research found an association between religiosity and obsessive-compulsive cognitions, a diagnosis of OCD created group homogeneity within which to study the individual experience. This is in line with guidance from Smith et al. (2009) which states that ‘the aim is to find a reasonably
homogeneous sample’ and that of Pietkiewicz & Smith (2014) who advise recruiting a defined group for whom the research problem has relevance and personal significance. The service does not differentiate OCD types, and our interest lay with these two phenomena, religiosity and OCD.

**Inclusion Criteria.** Individuals were required to be 18 years or over, residents of Northern Ireland and referred to Psychological Therapies Service (PTS) in the particular Health Trust. They were to be Christian (Protestant, Catholic or other Christian denomination). Diagnosis of OCD was to have occurred in adulthood. Participants must have progressed beyond assessment to intervention stage within the PTS service and were also eligible if discharged within the past six months. They also had to be able to communicate fluently in English. Individuals who had impacting trauma, co-morbidity in terms of any neurodevelopmental disorder, or those who were actively suicidal were not eligible for the study.

**Materials/Apparatus**

An interview schedule (see Appendix A) was devised primarily with the research question in mind. Questions were deliberately open-ended in line with Smith et al.’s (2009) recommended IPA approach as well as Yardley’s (2000) principle of sensitivity to context when conducting qualitative research. Given the dearth of similar qualitative research in this area and particularly the Northern Ireland context, the schedule questions were general, cautious and sensitive; for example, they did not specifically ask as to which Christian grouping an individual is affiliated.

The schedule reflected existing literature, for example experience of low mood. It was not however defined by the previous research in order to avoid
constraining the direction of the interview. Prompts were devised to encourage the participant to expand on their points as advised by Smith and Osborn (2003). These were piloted with the first participant, and then in line with IPA protocol (Smith et al., 2009) the interview was transcribed and analysed. The research team then decided that no revisions were necessary, and the interview was included in the study. Due to the fact that the first participant did not talk about religion for the first 45 minutes, a decision was made that if a participant had not mentioned faith within one hour, the interviewer could remind them of the research area, and ask them if they wanted to talk about their faith.

There were four interview questions with associated prompts. The questions did not ask about both religion and OCD as the research team made a conscious decision to let participants introduce this in their own way. This was in line with guidance from Pietkiewicz & Smith (2014) in designing open-ended questions free from hidden presumptions. It was important that an assumed relationship between OCD and religion was not conveyed through the questions as this may have influenced the participants. The participants were aware of the research area and had self-selected based on their religiosity. In this way participants were free to relate their experiences in their own way. Note that a funnelling process led the participant from more general to more sensitive areas and the interviews lasted between 45 and 75 minutes (Smith et al., 2009). A digital recorder was used to record the interview for the purpose of subsequent transcription and analysis.

A reflective diary was kept, recording the researcher’s thoughts and observations as the interviews developed. This was in line with recommendations for IPA research (Smith et al., 2009) increasing transparency as well as providing a personal narrative of developments.
Procedure

Participants were identified by PTS practitioners, based on inclusion/exclusion criteria information (see Appendix B). They were offered information packs which included an information sheet, a reply slip (see Appendix C and D) and return envelope. A record was kept (by PTS clinicians), of individuals who received packs. Those interested were able to complete the reply slip and consent form (see Appendix E) and return it to the lead researcher. A follow up reminder letter was sent (once) to those who do not return the forms (see Appendix F). The lead researcher communicated with clinicians as to who had sent in the forms, so that the PTS service knew who to send reminder letters to. In this way, the research team did not have access to potential participant personal details until the individual had expressed an interest officially. Therefore, the clinician involved was aware of their client’s interest but did not know what had been disclosed during interview, as data was anonymised.

Individuals who self-selected to be part of the research were invited to participate in the IPA study. In addition, they were sent a summary of the completed study if they expressed an interest requesting same. The contact details of those selecting to participate (on the reply slip) were received by the lead researcher who made contact by telephone and made an appointment with the individual. The interview took place following the schedule devised (see Appendix A), with
questions and prompts as appropriate. The interviews were audio-recorded. Participants were informed they could discontinue the interview at any point, and that the interview could be conducted over several sessions should they wish to do so. Participants were debriefed using the guidelines at the end of the interview (see Appendix G) and told about possible feelings they might experience and support available if needed. They were given a copy of support agencies. The debrief sheet had contact details of a Trust contact who was a member of the research team, whom they could contact regarding any aspect of the study. It also signposted them to contact their current therapist if they were still attending the service and needed to discuss their interview. Participants were reminded that they may withdraw their interview data within the next 14 days. No-one requested this. The researcher transcribed the interview onto a password-protected computer and followed university data storage procedures.

**Ethical Considerations.** Ethical approval was sought from the Office for Research Ethics Committees Northern Ireland and was granted on 23/04/18 (REC reference 18/NI/0043; see Section 7). Permissions was sought from the host NHS organisation, and this was also approved (anonymised as this would identify the Health Trust). The research team completed Good Clinical Practice Certificates as part of this process. A robust protocol (above) considered clinical governance such as confidentiality, anonymity, storage of data, and the welfare of the participants. Given the nature of the study, it was not envisaged that the interviews would cause distress, however a distress protocol and risk management protocol (see Appendix H) was devised using guidance from Draucker, Martsolf & Poole (2009).

**Data Analysis.** Data analysis was conducted using IPA research methods as laid out by Smith et al. (2009). This entailed an idiographic study of the individual’s
lived experience of the phenomena of religiosity and OCD, with emphasis on shared experiences and themes. The analysis followed Smith et al. (2009) guidelines for larger groups of data which recommend reading and re-reading, initial noting, identify emergent themes, moving to the next case and then looking for connection and patterns across cases.

IPA is a method particularly suitable for Clinical Psychology research as it strives to capture personal meaning from the lived experience, and this allows the psychologist to interact with the data at an ideographic level (Reid, Flower & Larkin, 2005). IPA was chosen as an appropriate starting point given the paucity of relevant research in the area. The unique context of Northern Ireland emerging as a post-conflict society, with its high level of church-going population, presented a rich seam of data. IPA is noted for the deep level of interpretation required from the researcher, termed ‘double hermeneutics’ (Smith & Eatough, 2007; Smith et al., 2009) due to the two layers of interpretation; the participant interprets their experience and relays this to the researcher, who then transcribes and pores over this data to elucidate further ‘meaning-making’. Due to the depth of interpretation required by the lead researcher, it was important to consider their positioning, their interest in the topic and their responses to data. The lead researcher was very open within the team about their own Northern Ireland upbringing in the Protestant faith, how an interfaith marriage led to many relaxed familial conversations about religion, but how they noted that religion and faith can be a difficult topic to discuss in Northern Ireland. This reflexive approach was recorded in their reflective diary. As agreed, the research team considered whether the lead researcher’s interpretations reflected the data set appropriately, and findings were discussed.
Initial coding and analysis produced numerous themes, and as individual interview analysis progressed, these were recorded and viewed in their totality upon finishing coding (See two transcript excerpts in Appendix I). The coding was defined by the research question, and so not all text regarding OCD or faith separately were coded, but rather the interaction between these two phenomena guided by Braun and Clarke (2013). Then as outlined above (Smith et al., 2009) themes were identified across interviews, and themes with no commonality were abandoned. This process is recorded in appendix J and K. An example of one of the discussions was that ‘faith and anxiety interaction (cycle/loop)’ was one of the codes (appendix J and K) which was not used. During a team discussion the code was considered to be more illustrative of OCD symptomology in general and was not a distinctive characteristic of its interaction with faith. The anxiety is held and described within the other themes, but they are more distinctive in encapsulating how OCD and religiosity interact.

Connections and patterns were considered and recurrence across cases was measured in order to approximate the strength of the theme (see Appendix L). In line with guidance from Smith et al. (2009) themes were required to be prevalent in at least 50% of the interviews to be classed as recurrent.

**Study Validity and Audit Trail.** The study followed agreed protocols as described. In addition, the research findings were presented to the Trust service user group as well as clinicians, and input welcomed. Those participants who requested a research summary were furnished with same.

In the execution of the research, a reflective diary was kept, and transcripts were stored safely in accordance with QUB and Data Protection policies. Regular
research team meetings were held, with discussion of findings and critical evaluation of interpretation. The research team reviewed the completed transcripts to verify authenticity and standard of work and were cognisant of themes reflecting the data appropriately. Study validity was enhanced by open recording of the analysis process (see Appendix J and K) and the measurement of recurrence of themes across all the interviews (see Appendix L). The process was iterative and only through moving back to the data and codes, and then back to the themes, the final themes and sub-theme were determined.

Results

Ten individuals who met inclusion criteria were recruited for the study. There were five males and five females. In terms of age range of participants two were 18-30 years old, four were 31-45 years, two were 46-60 years, and two were 61-75 years. The Trust uses a Stepped Care approach (Health & Social Care, 2017; see appendix M) which uses step levels to discern present need and severity of condition. Nine of the participants were assessed as step three-four and one was assessed as step four-five.

Following analysis, the themes fell broadly under three areas; conceptualisation, behaviour and belief. There were three themes in total; Faith and OCD Intertwined, OCD Impacting Faith Practice and OCD Blocking Connection to God. Note that all names and identifying details were changed to provide anonymity.

Faith and OCD intertwined

This all-encompassing theme is dominant throughout the research and indeed relates to subsequent theme discussion. All participants described how connected and inseparable their OCD and faith were. This relationship of course makes their
OCD distinctive. This was evident in a two-way system where not only did faith become influenced by OCD rituals and compulsions, but also religious faith impacted on their OCD presentation. This was depicted in how their OCD presented clinically and additionally in how they spoke of and tried to understand their situation. Participants described how their OCD affected all aspects of their faith, and this went beyond rituals, to anxiety and worry about thoughts, and worship practice. There were aspects of knowing, and then others of confusion and struggling to make sense of their condition.

“The OCD had set in in the house, what I used to do to help, to help me remember things I had done was attach a little prayer to whatever it was em the cooker or the immersion or whatever it was that I was afraid of leaving on. And then what happens of course, it’s always the same with OCD that it gets bigger and bigger and I think that for me the hardest thing was all these little prayers weren’t helping.”

(Josephine)

For Josephine, faith and OCD were intertwined and dual purpose. Prayer was used to remind her that she had performed the ritual, and therefore would not need repeated, but also the faith element she hoped would involve God or the saint in helping her stop performing the rituals. The use of language in how OCD had “set in” conjures up a contagious disease within the household. An image which is echoed in her depiction of the OCD spreading by getting “bigger and bigger”. The lack of control Josephine feels in this situation is also communicated, and yet there are attempts to garner some sense of control. The wistfulness that this is not working imbues much of the data.
As already described, OCD and faith enmeshment went beyond the clinical presentation and towards participants’ attempts to understand how OCD and faith interact.

“It’s difficult too, cos the OCD and the faith issues, they are very difficult to disentangle. So, I’m not sure how the OCD affects the faith, or the faith issues affect the OCD. Between the two of them, em... it does make your life unpleasant, and you don’t have satisfaction in your faith. This is a very difficult loop because if your faith issues are not sorted out then you do feel very, very bad. But whether that’s the OCD to blame for that, or the faith issues to blame for that, that’s a difficult one. So, I can’t really separate my OCD issues and my faith issues, that’s the problem, it’s like a big ball of knotted wool y’know.” (Brian)

Here, Brian describes not knowing how OCD and faith impact on each other, but that the outworking spoils his satisfaction within his faith. The dilemma itself is in how they interact, so one might know which element is to blame. The question goes unanswered due to the confusion the entanglement causes.

Holly talks through her understanding of the OCD-faith interaction, and it can be seen to change as she thinks about it.

“I think life experiences has contributed to OCD. Religion probably has an impact on it, but I don’t think it’s the cause of it. But I think it’s the impact it has on it ...... (she goes on to say) protecting people cos it’s my responsibility to protect them so... and again I think that probably can be religion-based cos I have it drummed into me that you have to be this Christian, good Samaritan.” (Holly)
Whilst Holly is at first certain that her faith did not cause her OCD, but rather impacts on it, she goes on to link her upbringing to be a good Christian Samaritan to the responsibility aspect of her OCD. Whilst it was clear that some of these questions were being considered for the first time, the data consistently showed how participants associated their faith with their OCD, and that this relationship was complex.

The interview excerpt from Eddie (appendix I) illustrate both the use of faith as a coping mechanism, to provide comfort and then its adoption within OCD rituals. Eddie describes his faith as a protective element for self and family, but how this moved on into OCD rituals, with faith part of these behaviours. Eddie views this as a progressive process. He is clear that faith existed first but is unsure at which point the rituals became part of his OCD presentation.

So, in this aspect of entwinement there was clarity and uncertainty. The data presented a certainty that the relationship existed, faith and OCD were entwined with each other, but an understanding of the nature of the relationship was more uncertain. There was a sense that causality was being questioned but that answers were not forthcoming. The analogy of tangled wool used by Brian is useful in showing how it can be seen to be tangled, in fact the various elements within it are clear; but how it became tangled, and how it can be unsnarled whilst keeping the strands of faith intact, is more difficult to answer or do.

**OCD impacting faith practice**
One theme emerged that typified behavioural responses to the interaction of OCD and religiosity, and this was the impact on faith practice, both internal and open.

**Internal faith practice.** The term ‘internal practice’ captures the cognitive and emotional components of worship, which were evident within the data. The transcripts frequently showed how individuals struggled with intrusive thoughts that impacted daily worship. Whilst OCD encouraged worship, focus and concentration on prayer or pure thoughts, the impact was not positive. There was a lack of satisfaction, a need to stay alert and on guard. Whilst some aspects of faith brought contentment, this was fleeting and reliant on certain faith behaviours performed by the participants. Internal faith was characterised by overthinking, second-guessing and predicting. Many of the cognitions were disparaging of the participant’s own faith behaviours or thoughts.

“*Sitting on a plane maybe saying a prayer maybe 20 times before we took off. Or four times maybe because we’re four of. Em but em aye it always used to be what if this plane crashes here? Or what if something bad happens on holiday? What if one of the kids are in the pool? Just stuff you hear what happens on holidays. You have a thought about it, and you’re scared that it could happen, so you do your ritual or say your prayer.*” (Dale)

Here Dale describes what should be an enjoyable life event, as he goes on holiday. But his thoughts cause him to utilise prayer in a compulsive manner, in order to protect his family. The use of many questions can be interpreted as showing the thought process conjuring up endless possibilities, and the anxiety within. There is a huge amount of strain being held, and the feeling of responsibility for his family
is clear. These internal behaviours were present across all the interviews, with participants drawing negative conclusions about them. And as before, some of the data examines these metacognitions.

“So, it’s pretty much if I’m trying to work out and do God’s working out and such in my own head like with this OCD and over-thinking and all that....

**G:** Okay so what does OCD represent then in relation to your faith?

**A:** It’s just a lack of faith then. I’m guessing now like. You know in regards to like as I was saying there like Christians are supposed to leave everything to God, but at the same time if we’re trying to grapple with all the different scenarios and all that in our own lives and trying to eh keep a hold of, like our work or just social life, whatever ..relationships..whatever maybe not giving it over to him just to say like okay do whatever you want to do rather than us trying to like manipulate circumstances in their own way of thinki...ways, if you know what I mean.” (Andy)

In this excerpt, Andy lets us know that these internal ‘grapple’ behaviours represent a lack of faith as issues should be given over to God. In this way, his hope to do the right thing and make the correct decisions, moves him further away from God.

**Open Practice.** The open practice of faith was highlighted throughout the interviews and naturally relate to internal faith practice. These behaviours such as church attendance, bible reading, and the outward acts of prayer were all out-workings of the individuals’ cognitions, and in a sense were the observable convolutions of faith that they themselves noticed. The difficulty that OCD and faith
interactions caused were clear. Worship patterns were altered, stepped up or avoided to relieve worries stemming from intrusive thoughts. The social aspect of faith featured here also, with examples of seeking reassurance about faith matters, inability to tell others due to fear of rejection, and observing how significant others did not understand their condition. The impact of OCD was a source of deep distress when there was a dissonance between their desired and actual behaviours.

“I don’t go because em it is such a stressful environment for me to be in em the stained glass windows, you’re in church it would just, being there for the hour or whatever the case would be and trying to have pure thoughts and a pure empty mind and have no evil thoughts or sexual thoughts or any of those thoughts coming into my mind y’know while I was in there em there would be no enjoyment going to church because the anxiety would be so high I would just be constantly trying to keep aw I’d be working so hard on my OCD to keep all that stuff out of my mind that I couldn’t actually...there’d be no point cos it’s too hard” (Colin)

Colin’s description of heightened anxiety due to intrusive thoughts highlights several other themes such as intertwining faith and OCD, as well as the interfering force of OCD. Indeed, his internal faith-related thoughts culminate in the outward behaviour of avoiding church. Another participant took this further as she predicts how others around her might feel if they knew exactly what was going on in her head.

“Some of them were just horrible em and I thought if I were to say those to anybody em that I didn’t know what would happen, but I knew I wouldn’t have friends. Y’know I sorta felt I would be put out of the group or something like that, em. So as a
result, what I did periodically was just stop going to church to see if it could make me feel better.” (Fiona)

Fiona referred to the imagined rejection if others knew what she was thinking, and this results in non-attendance of church in order to see if that helps. She went on later to describe how she feels unlovable by God, and she desperately wants to attend church. This moves beyond Colin’s description of church avoidance due to distressing faith-related images, to how others might view her, and the subsequent casting out from the group. The faith-OCD interaction involves a social circle, of which the church is part. And so, Fiona describes a rejection which is total, by God, herself and her peers.

**OCD blocking connection to God**

The final area related to the impact of OCD on belief. The theme of blocked connection was experienced in several ways. Whilst some detailed a movement in and out of fellowship, others depicted the struggle to put God first due to their OCD. There was also a sub-theme of OCD being a separate entity, blocking the connection by standing between God and self.

This gives us insight into how a blocked connection affects the individual and their attempts to understand it. Not having the desired relationship with God is value-laden within the parameters of faith rules. There is an anxiety that they are going off-track and not following God’s plan. At times, faith becomes irrelevant and individuals take on more responsibility for this than when OCD is felt to deliberately block their relationship. Ultimately this block impacts on hoped-for salvation and therefore responsibility is a primary concern.
“Well certainly aw it’s hard. In the past it would have affected my faith a lot, I guess. In that sometimes it felt irrelevant, if I’m quite honest at times my faith felt totally irrelevant because I was so in the throes of ruminating about something or, or… worrying about something that it takes over everything. Even your faith, that you can’t really pray, or you can’t really trust in God” (Kelly)

Kelly, by using the phrases ‘I was so in the throes’ illustrates how difficult it is to overcome the OCD and prioritise faith, as she would like. Kelly was clear in her interview that she wished for a faith free from OCD and this was a theme that emerged with several participants. There is also a sense that it is difficult to admit to finding faith irrelevant, as it is told as something that is safely committed to the past, and there is a need to say that she is being honest. Further insight is gained from Eddie, describing the void his OCD causes.

“I think that it actually ruins my faith. It blocks my connection with God. It definitely does like, I know that in my head, but I just can’t…. I’m hundred well ninety-five per cent positive that it blocks… it’s ruining my faith ruining my religion, it’s blocking my connection with God and cos of where it’s coming from and what’s doing it” (Eddie)

In this extract from Eddie’s interview we get a sense of his strong opinion on how OCD has impacted on his belief. And yet he doubts himself also, as he partly blames himself. There is a sense of longing for his faith, but that he feels it has been ruined. It shows a loss of something important to Eddie, and this is seen throughout the data. The blockage causes a loss in connection and satisfaction in faith.

Sub-theme: OCD as an interfering force: Participants described OCD as a separate force, pushing thoughts into their mind. Blame was apportioned towards this entity,
as well as on themselves. In addition, their Christian faith made this interference more distressing as the OCD knew how the content of the thoughts would impact on them.

The sense of OCD as a force or entity tells us that an understanding can be found in separating the responsible self from these intrusive thoughts. Responsibility remains an important part of their OCD, and yet this aspect is a departure, and could be interpreted as a coping mechanism, but not providing any relief.

‘I'd have to do something you know and then I would have to maybe pray “you see me God understand y’know that I’ve OCD and you know this isn’t (clears throat) I’m not having (laughs) these thoughts willingly.” Em stuff like that.’ (Colin)

“I think it’s a case of anything within the faith that makes the OCD worse my OCD having a mind of its own, knowing exactly the sort of thoughts that are against God, knowing I shouldn’t have those thoughts and therefore putting those thoughts into my head.” (Isobel)

Colin and Isobel felt attacked by their OCD. Colin felt he needed to explain to God that OCD was the cause of these thoughts. Isobel believed that OCD knew her particular vulnerability. In this extract she was portraying how her OCD deliberately inserted thoughts against God into her head, in a mischievous or, at worst, malevolent manner. The lack of control over interfering, intrusive thoughts, and the anxiety this brings, was also a feature of the data.

“And then other images start coming into your head and then even the devil and all would come into your head and you would have to ..that really…..that really the OCD makes you think you’re saying it to the devil and all. And you’re just it really,
it just, that just brings it to a whole new level and all if that pops into your head.”

(Eddie)

Here, Eddie describes how his OCD puts images relating to the devil into his head, and then manipulates his thinking into believing he is praying to Satan instead of God. The “whole new level” depicts the increased anxiety and distress that this causes, but that it is beyond his control. OCD appears to be an outside force.

Discussion

OCD and faith are intertwined in our findings. This macro-theme permeated every interview, and subsequent themes. This study brings a fresh perspective with the interpretation that at every level the participants attempted to understand this relationship. These metacognitions showed how an individual’s attempt to understand this connection, was valuable, even when it was elusive. Faith is a personal, organic and ineffable construct. It can be difficult to grasp, describe and comprehend. The divergence between faith as a coping mechanism and yet part of their OCD presentation was evident. Whilst this theme can easily dovetail into our previously explored understanding of the cognitive model as individuals described how their faith and OCD fitted into the accepted clinical presentation, the area worth considering is how they attempt to understand these experiences. Grappling with cognitions is notable. These individuals were not just relating an experience. They continued to interact with their experiences and try to make sense of them.

The behaviour theme captures the internal and open practice of faith. It was clear from the data that the faith-OCD interaction caused compromised worship. Examples were given of overthinking, predicting, repetitive prayer or non-attendance at church. Much of this could easily have been hypothesised, as these internal and
open behaviours fit with our knowledge of the cognitive model and an individual’s coping mechanisms of neutralising, atoning or avoidance. As such the work previously outlined by the Obsessive Cognitions Working Group (1997, 2001) was easily recognised within the interviews. However, the data contributed to our knowledge base further by revealing their efforts to understand this, the felt dissonance between their desired and actual worship and the dissatisfaction this brings. Moreover, the data highlights the intricacies of worship non-attendance, possible thought processes behind this, and the systemic dynamics of imagined rejection.

Finally, this study recognised the blocked connection experienced by individuals in their relationship with God. The ruination of this dimension of faith was felt as a loss. The resulting movement in and out of fellowship, or the felt isolation from God is a new aspect in our knowledge of the faith-OCD interaction. This is likely due to the qualitative nature of the study, which allowed this theme to emerge. Previous research highlights the cognitive and emotional struggle in the relationship, but not the felt barrier. Theoretically, this is possibly an outworking rather than an integral part of the cognitive model. However, it may be important to examine the cognitive and emotional response to this impasse, and the wellbeing or possible risks in an individual who feels cut-off from God and condemned from within and without. The aforementioned research by Abramowitz (2004) which found lower levels of depression in Protestants with OCD was not experienced or felt within the data. The church and social aspect was not represented as a protective factor. The blocked connection theme embodies a sense of isolation, lack of hope, and depiction of loss.
The data was in keeping with previous findings on several points, such as intrusive thoughts, severe distress, and inflated responsibility (Salkovskis, Shafran, Rachman & Freeston, 1999). However, a novel aspect of this study is that OCD thoughts were often interpreted as an interfering force, at times separate and as another entity. This is a subtle shift from the cognitive model’s theory that an over-inflated sense of responsibility to block or atone for intrusive thoughts will lead to further compulsive behaviour. Whilst this behaviour was present the interpretation was not so stark. The question of whether this was a successful coping mechanism or mediating tool is not clear but is of clinical interest. Whether people of a religious faith, due to their belief in an omnipotent being can also ringfence the intrusive thoughts as being from outside themselves, is a hypothesis worth pursuing. It was observed that at no time did participants liken the outside force to the devil. This is noteworthy and illustrates the importance of examining what is being communicated, and the nuance of same. Whilst the devil was referenced, the OCD was blamed for forming the cognition.

**Strengths and Limitations**

This study has contributed to our knowledge of an understudied area by allowing the subjective voice to be heard. Interpretative Phenomenological Analysis, with its homogeneous sampling, and semi-structured interview format gives greater ecological validity to the data. Moreover, the study did not differentiate between individuals presenting to the service in terms of any assessed or presumed subtype of OCD, but rather sought to examine the lived experience of OCD (in general) in the context of their religious beliefs. This is a strength as it recognises the previous research that identifies Obsessive-Compulsive cognitions associated with religiosity.
The study protocol stipulated that participants should be fluent in English. This limited recruitment from a more diverse population. In addition, participants were selected from those who presented to treatment within the Psychology service and were therefore help seeking. Future research could attempt to include a wider range of participants from a more diverse cultural population. There are also opportunities with other religious populations to examine transferable elements of this study, such as rationale, methodology and a comparison of interpretations and themes, but this would be limited to Christian populations.

Clinical implications

The data demonstrates the importance of using clinical assessment to garner faith beliefs. Clinicians may consider asking clients to describe their OCD in faith terms if relevant. Inclusion of questions regarding faith on assessment pro-forma might allow these conversations to begin. Furthermore, the use of this understanding will help the process of formulation. Westbrook, Kennerly & Kirk (2007) comment on how formulations can help as a tool in making sense of ‘chaotic confusion’. This has echoes of the grappling and search for meaning described by participants in this study. When formulating, practitioners could consider the nuances of responsibility thoughts, and how a religious client may respond to intrusive thoughts that attack their faith values.

Whilst the IPA approach does not eschew generalizations, the analysis of these particular lived and felt experiences may encourage clinicians to allow other unique interpretations to become part of the therapeutic process. These insights may
be helpful when designing interventions and agreeing treatment goals. In addition, therapy may wish to explore a possible sense of loss clients might feel due to compromised internal or open faith practice, or the loss of connection with God.

**Conclusion**

This study provides rich subjective data on the lived experience of OCD and religiosity. Through the process of analysis and interpretation, themes have emerged which capture these experiences and tell a story. The overarching theme of OCD and faith intertwined scaffolds the whole framework of the data, with OCD and faith impacting on each other consistently. OCD and religiosity were experienced behaviourally as an internal compromised faith, with open practice experienced by most as inconsistent or impossible. The final theme was relating to the blocked connection with God due to OCD, the ensuing loss, and the concept of OCD as an interfering force. Whilst these themes confirmed the cognitive model of OCD in terms of distress caused by intrusive thoughts and the compulsion to reduce anxiety through rituals, atonement or avoidance, the data brought a new perspective on the depiction of these intrusive thoughts as a separate entity, and the search for understanding experienced by individuals. In addition, the losses due to avoidance of faith practice and the blocked connection were imbued with great detail and colour.

The data brings a richness to our knowledge base, and important perspectives in how OCD and religiosity are experienced and felt. Clinically, this area could be given attention during assessment, formulation and intervention, with possible losses acknowledged, whilst subjective understanding is sought. Future research could perhaps concentrate on how individuals who are religious and are diagnosed with
OCD cope with intrusive thoughts and how our understanding of this area can be used to help individuals make sense of their experience and reduce distress.
References


Bunting, B. P., Murphy, S. D., O'Neill, S. M., & Ferry, F. R. (2012). Lifetime prevalence of mental health disorders and delay in treatment following initial onset: evidence from
the Northern Ireland Study of Health and Stress. *Psychological medicine*, 42(8), 1727.


Section 5: Appendix A: Interview Schedule

INTERVIEW SCHEDULE

Introduction

1. Introduce myself and try to encourage participant to relax (build rapport).

2. Complete and sign consent form, encourage questions and make sure participants understand what the interview will entail.

3. Explain purpose of research:
   ‘This study hopes to explore the lived experience of OCD with people who have high religiosity (that is they are religious). The interview will allow you to discuss your own personal experience of this.

4. Explain how the interview will proceed and reiterate their right to take a break, stop or withdraw information up to 14 days from interview, should they so wish.

5. Explain again the limits of confidentiality and ensure that they understand.

6. Ask if there are any questions and begin the interview (using audio-recorder).

Question One:

What was your first experience of OCD?

Prompts:
How long ago was this?
How had things been for you?
What types of thoughts, obsessions and compulsions had you been having?
What prompted you to ask for help?
Tell me about that?
Question Two:

**How does OCD effect your everyday life?**

Prompts: Thoughts, daily routine, emotionally, socially/relationships, physical sensations.

Question Three:

**How does OCD affect your view of yourself?**

Prompts:
What is that like?
View of the world?
View of your future?
Does that affect your mood?
Tell me a bit more
Why do you think that is?

Question Four:

**Is there anything else that as part of your experience of OCD that you haven’t been able to talk about?**

Prompts:
Tell me more about that
Does anything help with that?
How is that for you?
Would you view that as a good or a bad thing?

Thank participant for taking part in the interview

**DEBRIEF**

7. Ask what was it like talking about OCD?
8. Reiterate how and where data will be stored confidentially.
9. Reiterate that they can withdraw their interview if they wish.
10. Ask if there is anything else they would like to discuss.
11. Show participant the debrief sheet and highlight support networks they might use.

Appendix B: Information for Clinicians

RESEARCH STUDY: The lived experience of OCD and religiosity: An Interpretative Phenomenological Analysis.

This research study aims to investigate the lived experience of Obsessive–Compulsive Disorder (OCD) in people who are also religious. The research is being carried out by Gayle Hegarty Trainee Clinical Psychologist, as part of her clinical training. The project requires approximately 10 participants who are currently living with OCD, who also have a Christian based faith. It is hoped that these participants will be recruited from within the Psychological Therapies Service in the xxxx Health and Social Care Trust. To this end, we require the assistance of clinicians to let potential participants know about this research project.

As a clinician, what do I need to do?

1. Identify clients discharged in past 6 months, currently on your caseload now or over the next nine months who are living with OCD and meet inclusion criteria. (see criteria overleaf).

2. Let them know that a study is taking place examining the lived experience of OCD and religiosity. Clients can self-select.

3. Give each client a Participant Information Sheet, which describes the study and contains a reply slip for clients to provide their contact details if interested in participating. Send the Invitation Letter if client is discharged.

4. Tell the client that you will not know what they disclose during the interview, unless they tell you themselves.

5. Keep a record of clients you gave information to (and the date). Dave Rogers and Gayle Hegarty will be in touch regularly with you. If we haven’t heard from these clients in 4 weeks we would like you to send them a reminder letter (supplied).

What is required of the client?

Clients who you have identified as living with OCD should

1. Read the Participant Information Sheet provided by you. If clients want to take part, they write their contact details on the reply slip and either leave the slip in the sealed box at reception or post it themselves. They can also express interest by using the email/phone number provided. The researcher will contact them to arrange a meeting to complete the study.

2. The client will be asked to attend a PTS service of their choosing in the Trust to complete the research interview (lasting between 45 - 90 minutes in total). The
interview asks four general questions about living with OCD, with some prompts to help them expand on their answers. This shall be recorded.

3. Participants shall then be debriefed and have 14 days within which they can withdraw their interview. After this point the interview shall be transcribed and undergo analysis.

Inclusion Criteria

- Adult 18 years or over
- Both male and female
- Residing in Northern Ireland
- Referred to PTS xxxx Trust
- Onset of OCD occurred in adulthood
- Progression within PTS service beyond assessment into intervention stage
- Christian faith - Protestant, Catholic or other identified Christian faith (client to self-select)
- Ability to communicate fluently in English language

Exclusion Criteria

- Under 18 years
- Not residing in Northern Ireland
- Not referred to PTS xxxx Trust
- Not progressed through assessment to intervention stage
- Those who are actively suicidal
- Co-morbidity in terms of any neuro-developmental disorder
- Identified impacting trauma (childhood or otherwise)
- Onset of OCD occurred in childhood
- Those unable to communicate in an interview in the English language
Dear

The Psychological Therapies Service (PTS) wanted to let you know that some new research is being carried out within the xxxx Trust in partnership with Queen’s University, Belfast. It is hoped that this study shall give us an understanding of the lived experience of Obsessive-Compulsive Disorder for individuals who are also religious. This is an area that has had little research done and it may help both practitioners and service users. It will involve one interview which should last 45-90 minutes. As you were attending this service until recently, I wanted to give you the opportunity to take part.

I have enclosed an information pack which will explain more about the study and who is suitable. Should you wish to take part, please complete the form and send back to the address given or email ghegarty02@qub.ac.uk expressing your interest. You can also drop it into the sealed box in reception of your local PTS service.

Yours sincerely,
PARTICIPANT INFORMATION SHEET

My name is Gayle Hegarty and I am a trainee Clinical Psychologist at Queen’s University Belfast. I am really interested in the lived experience of Obsessive-Compulsive Disorder for those who are also religious. There is very little research of this type and none in Northern Ireland. I am hoping to explore your experiences and find out what this has been like for you. This study is a collaboration between Queen’s University Belfast and xxxx Health and Social care Trust.

Do I have to take part?

This is completely up to you. It does not affect any aspect of the care you receive with your therapist in fact your therapist will not know what you said during interview unless you tell them. You are free to withdraw from the study before or during interview and participation is entirely voluntary. You can also request that the interview data be withdrawn up to 14 days after interview.

What will happen if I take part?

The lead researcher Gayle Hegarty shall arrange a suitable time to meet so that the interview can take place. The interview lasts between 45-90 minutes and you will be asked to talk about your experiences living with OCD. It is up to you how much or little you talk about and there will be breaks if needed. The interview will be audio-recorded so that the researcher can listen back to it. The interview will take place in the Psychological Therapy Service (PTS) building where you have attended appointments or in one of the other PTS buildings. You can decide what suits best.

Am I suitable?

The study will be examining the experiences of people living with OCD and are also religious. We would like to interview people who have a Christian based faith. This can be ANY of the Christian based faiths and is not restricted to any denomination or church. You do not need to be highly religious (but you can be). Not everyone will feel that they match this study’s requirements. You can still receive a summary copy of the study, when it is finished (if you so wish).

Are there any benefits in taking part?

This study gives you an opportunity to talk about your own experiences, thoughts and feelings. It is possible that talking about such things could be a little uncomfortable, but people generally find the experience to be positive.
Will my participation in the study and the information I provide be confidential?

All personally identifiable information in this study will be kept confidential. The record of names will be kept separate from the interviews. All the interviews will be transcribed with any identifying details changed. They will not be shared with the PTS service/ your therapist. Only the research team shall have access to the transcripts, and this shall be after names and details have been changed. The information will be kept securely at Queen’s University Belfast Clinical Psychology Department for 5 years, before being destroyed. The lead researcher (Gayle Hegarty) will write about the research as part of her studies (Doctorate in Clinical Psychology). The research may be published in academic journals or presented at conferences and quotes from the interviews may be used. You will not be identifiable from these quotes. You will have the opportunity to read a summary of the findings if you wish.

Are there any limits to this confidentiality?

If you disclose information that you or someone else is at risk of harm (from self or others) the researcher is obliged to pass on the information to an appropriate person (e.g. GP, Social Services, PSNI, etc.). Should this arise, it would be discussed with you.

What if something goes wrong?

If you have a concern about any aspect of this study, you can speak with the Chief Investigator, Lesley Storey 028 9097 4587. If you remain unhappy and wish to make a formal complaint you may do so by contacting the xxxx Trust. You can contact them at The Complaints Department (address removed to not identify Health Trust)

What should I do next?

If you would like to participate in this study, please complete the reply slip enclosed or contact a member of the research team on the details below.

Gayle will then contact you to arrange a suitable time and date for the interview.

Best wishes,

Gayle Hegarty

Contact details

Gayle Hegarty, Lead Researcher, Queen’s University Belfast
ghegarty02@qub.ac.uk

Dr Dave Rogers, Principal Investigator, (email address removed to not identify Health Trust)
Appendix D: Reply Slip

REPLY SLIP

I have read all of the information sheet and I
Miss/Mrs/Mr__________________________ would like to take part in this research.

My telephone number
is____________________________________ and I understand that you will contact me to arrange a suitable time to meet.

Please send the completed reply slip to:

Mrs Gayle Hegarty, Dept. Of Clinical Psychology, School of Psychology,
David Keir Building, Queen’s University Belfast, BT7 1NN

or use the provided envelope.

Alternatively scan and email this reply form to ghegarty02@qub.ac.uk

If you have contacted Gayle Hegarty or Dave Rogers to tell them you would like to take part in the study, you do not need to complete a reply slip. Gayle Hegarty will be in touch to arrange an interview.

I look forward to meeting you.

Gayle Hegarty
Trainee Clinical Psychologist
Appendix E: Consent Form

Study Title: What is the lived experience of Obsessive-Compulsive Disorder and religiosity? An Interpretative Phenomenological Analysis.

(Please tick)

1. I confirm that I have read and understood the Participant Information Sheet for this study

2. If I have any other questions I can ask Gayle Hegarty (researcher) today. I also have contact details of the research team

3. I understand that my participation is voluntary and I can stop taking part in the study at any time. I can withdraw my information up to 14 days after the interview. This will not affect my care.

4. I understand that if I tell the researcher that I or someone else is at risk from harm (from self or others) the researcher will be obliged to pass this information on to an appropriate person.

5. I understand that this research is being carried out by researchers from Queen’s University Belfast and that my information will be held securely on the University premises in accordance with the Data Protection Act 1998.

6. I agree to my interview being audio-recorded and transcribed into written format. I understand that my direct quotes may be used in publications. I understand that all identifiable details will be changed.

7. I would like to receive a summary copy of the study. Yes No (Please circle)

8. I consent to take part in the above study.

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Name of Participant            Signature            Date

----------------------------------  ----------------------------------  --------------
Name of Researcher            Signature            Date

(Gayle Hegarty)
Appendix F: Reminder Letter

Dear

You may recall that some time ago you expressed an interest in taking part in a study is being conducted through Queen’s University Belfast and the xxxx Health and Social Care Trust. It is hoped that this study shall give us an understanding of the lived experience of Obsessive-Compulsive Disorder for individuals who are also religious.

I have enclosed another information pack. Should you still wish to take part, please complete the form and send back to the address given. You may have further questions. You can contact a member of the research team at Dave.Rogers@xxxxtrust.hscni.net  Tel: 028 xxxx xxxx

Yours sincerely,
Appendix G: Debrief Sheet

Thank-you so much for taking part in this study. I hope it has been a positive experience. If you do feel distressed or concerned please do not hesitate to contact your PTS therapist or GP. In addition, the agencies below and websites may be of benefit.

**OCD UK**
UK organisation with a support group available in Belfast. Meeting details at [belfast@ocduk.org](mailto:belfast@ocduk.org)

**Recovery College Tel: 028xxxx xxxx**
A community-based programme of support, wellness, life-long learning and empowerment.
(email removed so as not to identify Health Trust)

**Lifeline Tel: 0808 808 8000**
Lifeline is the Northern Ireland crisis response helpline service for people who are experiencing distress or despair. Lifeline counsellors are available 24 hours a day, seven days a week to listen and help.

**Dr Kevin Dyer** Clinical Psychologist, xxxx Trust. [K.dyer@qub.ac.uk](mailto:K.dyer@qub.ac.uk)
Tel: 028 xxxx xxxx
Appendix H: Risk Management Protocol

1. Managing Distress

It is possible that speaking about issues could cause a participant some distress. A ‘Debrief Sheet’ will be given to all participants, so that following the interview they can access support or more information. A distress protocol is detailed below, and this will be followed should the participant become upset during the interview. It is envisaged that the participants shall still be attending PTS services. In which case they shall be directed to speak to their therapist in the first instance. A named Clinical Psychologist within the xxxx Trust shall also be identified, and their telephone number given. If a participant has been recently discharged from PTS, they will be advised to contact this named individual, access their GP, or the organisations on the ‘Debrief Sheet’. The details of a Clinical Psychologist within the research team are also on the ‘Debrief Sheet’.

2. Managing Risk

The research team will follow guidelines regarding disclosure as detailed on the consent form and agreed with the participants prior to interview.

If there appear to be safeguarding issues (child welfare) then the Gateway Team shall be informed. The safety of the participant shall at all times be taken into account. In addition, the welfare of children and therefore any information regarding their safety, is of paramount importance. Risk resulting from distress shall be dealt with as detailed in the ‘Managing Distress protocol’ below.

3. Ethical Consideration

The research team have two members who work within the xxxx Trust PTS service. It has been decided that clients who have attended therapy with these Clinical Psychologists shall not be invited to take part in the study, in order to ensure that additional knowledge shall not be allowed to skew/bias data analysis.

Distress Protocol

Participant Distress During Interview

If the participant indicates verbally during the interview that they are experiencing emotional distress

Or
If the participant exhibits signs of experiencing emotional distress (e.g. uncontrollable crying or shaking) that would suggest that the interview is too stressful.

Stage 1 Response

The interview will be discontinued

The researcher will offer support immediately and assess risk

E.g. Tell me what thoughts you are having?

Tell me what you are feeling right now?

Do you feel you are able to go on about your day?

Do you feel safe

Review

If the participant feels able and researcher believes the participant is able to do so, the interview may be resumed

Provide participant with contact numbers of support agencies

Continue to stage 2 response if the participant is deemed unable to continue

Stage 2 Response

Discontinue interview

Encourage participant to attend GP or mental health professional

Provide participant with contact numbers of support agencies

Signed consent will already have been given to contact the relevant health professional regarding the participant’s safety, however the researcher should speak to the participant about the need to share this information with a health professional, in order to protect them from harm.
Appendix I: Two Interview Excerpts with initial notes (left) and coding (right)

G: Okay, and home.. you said it is there at home as well?
B: it’s what sorry?
G: You said it is there at home also
B: It is yes. it’s the same really.. yeah... I don’t have it all the time, sometimes weeks, sometimes occasionally two weeks might be good em it just varies really.
G: Okay, em now you’ve touched on this a little bit, but I’m interested how the OCD affects your view of yourself.
B: Of myself?
G: Yeah.
B: (Large sigh) Em... I suppose it makes me very frustrated really.
G: Okay
B: And it’s difficult too cos the OCD and the faith issues, they are very difficult to disentangle. So I’m not so sure how the OCD affects the faith, or the faith issues affect the OCD. But between the two of them em... it does sorta make your life unpleasant and,
you don't have satisfaction in your faith, you don't have something driving you forward, motivation wise. So you do become very discouraged, I'll say that's one of the ways it certainly an effect, you become very discouraged and I do have to battle against this sense of hopelessness that I may not be getting better really, and what would be the end game if that was the case, which doesn't seem to me a very nice thought. My therapist doesn't allow me to think that way but y'know it's just there in the back of your mind, is this the last chance. Cos I have had a lot of therapy. Not necessarily for OCD but just quite a lot of therapy over my life from the time I was probably in my teens....

G: Okay, and the end game you have mentioned several times.

B: Yeah

G: Is that another thought that needs to be avoided?

B: Yeah I suppose it does or no well you can't really repress thoughts like that, you shouldn't really but it's just the thought what
happens if I finish here and I’m not better where do I go and what do I do, do I want to live, how do I want to live? It’s just not a very pleasant thought but it’s still there, so em... again also OCD affects you in a sense to do with your self image and worthiness y’know so it does lower your sense of self worth and because of the faith issues if you think faith’s important to you then because of the OCD or the interaction between faith and OCD well then you’ve an awful lot of negative thoughts about faith and God too.

So it becomes a bit of a circle really, anger against God y’know and as I say I’m not exactly sure what the balance is between which one affects the other most.

G: And how do you cope with that anger?

B: (Blows air outwards) You don’t really cope with it I suppose. It’s just there and sometimes I confess it and sometimes... but it’s more just a kind of undercurrent I suppose rather than always being an obvious thing. But it’s just, it’s difficult for me to know how to live my life at the present time really and that is the problem, between faith not...
God?

Q: God?

working, you know faith not being real, is there a God? You know all these thoughts, why am I not getting better even... you become sort of it becomes a kinda knot if you know what I mean; difficult to unravel... I feel much better faith-wise when I'm not suffering OCD, I have a better view of myself and faith, but I'm not sure what that really says. Em I can get very, if I have a bad episode of obsessive thinking I can get very down, you know and it feels quite hopeless. I've never tried to commit suicide or even considered it but you know you kinda wonder was it a good thing to have been born really, it would have maybe been better not to have been born

But that's looking also at a lot of things in my life you know that have been problematic you know. Emotionally and psychologically over a long period of time, not just the last few years.

G: So, I suppose... we've touched on what's the view of the future and the struggle with that sometimes...

B: Ahah, ahah
G: Em... and your view of yourself. I suppose there's another aspect as well of what your view would be of the world in general.

B: The world in general, ahah?

G: In relation to your experiences and your OCD and your faith... how that impacts on your view of the world?

B: Yeah I mean, sometimes the world's a very threatening place to be as well y'know, all sorts of things, I tend to be a very anxious person anyway and em I think I mean obviously I've just got a world view. Y'know whether we acknowledge it or not, we do. And even people who say they don't believe, or have no faith, they do believe in something y'know. So I think OCD makes it difficult to know what to believe because it's related to faith. Cos obviously faith should be the most important thing in your life, and your driving force, but then with the problems of OCD and faith well then you tend to be living in a bit of a vacuum to be honest. You tend to live a lot sometimes just trying to get through the day.
G: Okay.

B: Which prevents you from having a positive world view.

G: Okay, and that vacuum, is that the OCD or is it in relation to the faith or is it both?

B: I think it's both really, yes it's both.

Struggling with the OCD and struggling with faith. Together I think leaves you in kind of a sense of a vacuum in that you find it difficult to know exactly what you believe. I think that's the problem. You can say you believe one thing but do you really believe it. Y'know and how does the reality of what... of the way things are and what is happening, how does that relate to your faith. So I think those are difficult issues.

G: Can you give me an example of that, cos that's very interesting, y'know the reality of how things are and...?

B: Well I suppose I mean you want to... I want really basically to be a positive person who attributes to and helps people, but I find that when I have a lot of OCD and
the thing, the earliest thing I can remember
y’know.

G: Okay

E: That’s the earliest OCD I can remember.

G: Okay and then did it develop from there?

E: It kept progressing. I think it wasn’t long
after that stuff started, um see my Granny
and Granda lived with us and my Granny and
Granda were very religious and there were
like pictures of Jesus and God and statues of
Mary and all, everyting all over the house. I can
remember I don’t know what sparked it off
em a stat. at the top of the stairs there’s like
a wee thing of Mary y’know and Jesus,
holding baby Jesus, and I just got it in my
head I had to stop and say em certain
phrases but I can’t remember exactly what
the phrase were then cos’ it’s moved on since
then. I can’t remember what exactly I said
then but that’s I can remember I think that’s
when the religious part of it started. I’m not
sure how long it was after the OCD started

G: Okay. And why do you think you thought
that that would be a good thing to do?
E: Em I'm not really sure, I can't em if ... well
I understand now I have OCD it was sort of
the OCD making me do it but then I didn't
know what OCD was 'til I was in my twenties.
So didn't even know. I thought I was the only
person with this and didn't know what it was
and then it just sorta stopped. different
things started happening and then but the
OCD had changed a whole lot of times over
the years like and the ... different things have
moved in but the religious thing has always
stayed there.

G: Okay

E: It's never went away

G: I'm really interested in what you were
saying about remembering going up the
stairs and thinking that you had to stop.

E: Yeah

G: Em I'm wondering what it was or even
what the feeling was or y'know what, how
you felt it would help, to do that?

E: Em I think I felt em that OCD was all about
protecting my family and all, and my Granny
and Grandad. And I thought that em God like
em God and anything religious would be the best thing to protect the family and the OCD just turned it into something uncontrollable like.

G: Okay, so stopping and saying those phrases would help em protect your family.

E: Yeah.

G: And you, or...?

E: Well mostly my family but sort of a wee bit me but not really, mostly my family like.

G: And so repeating these phrases. Do you think they were religious phrases, I know you can’t remember what they were, religious phrases or prayers or

E: They definitely were em prayers or religious phrases I made up in my head because I still say other religious phrases but they’ve changed now from what they were.

G: Okay, And how long would that have taken to say those things.

E: At the start it was just em ... a couple of things I remember it’s just as time went on it got longer and longer it took more, it took
more to, to make me feel safe and right and
okay and the more I done it the more, it's like
it evolves. All every else with OCD it's like
the more you do it the more you have to, the
more, it's like the more you have to keep
doing it or something. Just, and then it just
gets out of control. It starts off as just
something simple and then just snowballs,
just ...

G: Okay, thank-you. And how had things
been for you at that time when that started
ehm having OCD type behaviours.

E: Well there was a lot of stuff going on
where I lived, there was em there was a

and all at the time, and I've seen r

now and I
just seen, at that age like I just seen a load of
stuff like. I remember, I remember one time
ah there was like a fella just outside our
house, every all the houses all the houses
had wee wall. And my ma must have knew
him, must have knew something was going
to happen cos she was watching him. He put
his foot up on our wall, and moved his coat
Appendix J: Example of work on codes connecting to emerging themes

Conceptualising the interaction of OCD and religiosity

30/3/19 Further theme work. Grouped some more themes together.

1. Faith and OCD intertwined (new codes added)

Every aspect of faith linked with worry and OCD cognitions

View that OCD and faith shall always cause personal hardship

Religious OCD a constant throughout life.

(this captures the idea that this is lifelong, constant and difficult)

2. Faith and anxiety interaction (cycle/loop)

I have begun to think about how anxiety and faith interact. Important to conceptualise this. Faith increases anxiety (intrusive, forceful, punishing) and faith reduces anxiety (provides protection, numbs and calms). Here we can include the view that OCD is a malevolent force. Codes below:

Cognitions causing increase of anxiety and worry

Acts of faith (normally prayer) being utilised in OCD rituals to protect self and family

Every aspect of faith linked with worry and OCD cognitions

Heightened anxiety that bad things could happen for displeasing God (maybe this links with the protection theme)

Concern that not praying will mean bad things could happen

OCD as an interfering force, manipulating faith

OCD as a separate and malevolent force

OCD as a separate powerful and malevolent entity.

OCD as an established all-consuming force, manipulating faith

Protection and reduction of anxiety:

Compulsion to pray reduced anxiety and provided protection

Protection of family is the ultimate goal of the compulsions

Use of faith to comfort, numb and manage OCD

Religious OCD serves as family and self-protection
Use of prayers to numb and calm.
Utilisation of faith teachings to comfort and manage OCD

Notes: OCD is seen as a lack of... in many cases, faith is viewed as a way of protecting and so reduces anxiety, but also something that increases anxiety if needs not met. It’s a cycle. Difficult to know where one starts and ends. Participants said they saw OCD as a malevolent force, making them anxious, causing thoughts to intrude.

Issues with behaviour
OCD impacting practice of worship (prayer, reading and attendance)
Faith requires the internal practice of worship:

1. OCD impacting (helping and hindering) the cognitive and emotional practice of worship (needs to be more succinct wording)

Cognitions causing increase of anxiety and worry
Sexual thoughts pushing into religious thought
OCD-faith interaction represented by sexual cognitions, blaspheming God and feeling displeasing to God.
Religious figures and emblems a particular OCD target
Every aspect of faith linked with worry and OCD cognitions
Concern that not praying will mean bad things could happen
Use of prayers to numb and calm.
Use of faith to comfort, numb and manage OCD
Utilisation of faith teachings to comfort and manage OCD
Compulsion to pray reduced anxiety and provided protection

2. Impact on physical worship behaviour
Inability to attend church
OCD impacting religious practice and causing non-attendance at church
Issues with belief

1. The struggle to put God first, before OCD.
God's plan viewed as important (possibly only in two)
Emphasis on leaving issues with God
OCD-faith interaction represented by overthinking and predicting
OCD a test from God which needs to be handed over to him

2. OCD interfering with faith relationship
OCD blocking connection to and view of God
A movement between being in and out of fellowship with God.
Desired comfort and freedom of an unfettered faith
Religious OCD a constant throughout life.
View that OCD and faith shall always cause personal hardship
Feeling that one has failed God and deserve punishment
Appendix K: Further theme work and accompanying email

Original themes yesterday

Conceptualising the interaction of OCD and religiosity

1. Faith and OCD intertwined
2. Faith and anxiety interaction (cycle/loop)
   Embodiment of faith-OCD interaction?

Issues with behaviour

1. OCD impacting (helping and hindering) the cognitive
   and emotional practice of worship (wording… please help!!)
2. Impact on physical worship behaviour

Issues with belief

1. The struggle to put God first, before OCD.
2. OCD interfering with faith relationship

New thinking!

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<tr>
<th>Super-ordinate Themes</th>
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<td>Conceptualisation</td>
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<td>OCD as an interfering force</td>
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<td>Open practice</td>
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<td>Belief</td>
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<td>OCD blocking connection to God</td>
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</table>

Note: Following this work ‘OCD as an interfering force’ was moved to the belief section as it fitted within the theme of blocked connection. Then it became a sub-theme.
Further work

Lesley Storey <l.storey@qub.ac.uk>

Mon 08/04, 09:15

Hi
That's much better now, there is a coherent narrative coming from the themes to address the research question.
Title - I don't think you need the quote - "the lived experience of OCD and religiosity: an interoperative phenomenological analysis" would be ok. I wouldn't try to squish the review into a single title; just add it separately.
Target journal - it depends who your ideal target audience is; IJQRT won't get to practitioners; you could also look at one of the psychology of religion options for another angle.

Lesley

Gayle Hegarty

Fri 05/04, 14:41

Lesley Storey

Theme work 4thApril.docx
18 KB

Download
Save to OneDrive - Queen’s University Belfast

Hi Lesley,
I have done a good bit of pruning and gone back and forth a few times and taken things out and put things in.
I now have five main themes. Faith and OCD intertwined is present in every interview. Is it an overarching theme, or a macro theme as you called it?
I took out anxiety (several times) as it represented the normal OCD cycle and therefore I put 'OCD as a malevolent force' in there as I think it is different, in
that the OCD is viewed as putting these thoughts in deliberately to distress them
given their faith.
I took out 'overthinking and predicting' as part of the Belief section as this is normal
OCD cognitions also. So, Belief section only has 'OCD interfering with faith
relationship' now. I can include the ideas that there is 'a struggle to re-establish
relationship' and also 'The struggle to put God first before OCD' as we had
discussed this yesterday as falling under the one heading also. I did have both of
these in separately and they were present in 5 or 6 interviews, but I feel they fall
under 'OCD interfering with faith relationship'. Is that okay to take them out and
discuss them in the section as ideas that some participants talked about?
I feel happier and more confident that these are more succinct and have checked
them across the interviews. There is a table there that shows how many they are
found in.
Have you any concerns that I have missed anything out?
I was thinking I might start writing it up now.
Regards,
Gayle
Appendix L: Table showing prevalence of themes across interviews.

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<th>Theme</th>
<th>Andy</th>
<th>Brian</th>
<th>Colin</th>
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<th>Eddie</th>
<th>Fiona</th>
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Appendix M: ‘You In Mind’, Stepped Care Model for Mental Health Services in Northern Ireland

**Step 1:**
Self directed help and health and wellbeing services
Support at this level usually involves responding to stress and mild emotional difficulties which can be resolved through making recovery focused lifestyle adjustments and adopting new problem solving and coping strategies.

**Step 2:**
Primary Care Talking Therapies
Support at this level usually involves responding to mental health and emotional difficulties such as anxiety and depression. Recovery focused support involves a combination of talking therapies and lifestyle advice.

**Step 3:**
Specialist Community Mental Health Services
Support at this level usually involves responding to mental health problems which are adversely affecting the quality of personal daily and/or family or occupational life. Recovery focused support and treatment will involve a combination of psychological therapies and/or drug therapies.

**Step 4:**
Highly Specialist Condition Specific Mental Health Services
Support at this level usually involves providing care in response to complex specific mental health needs. Care at this step involves the delivery of specialist programmes of recovery focused support and treatment delivered by a range of mental health specialists.

**Step 5:**
High Intensity Mental Health Services
Support at this level is usually provided in response to mental health needs, including adopting new problem solving coping strategies, which involves the delivery and intensive recovery focused support and treatment provided at home or in hospital.
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University of Connecticut

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- Identify key issues/topic under consideration.

Author Note
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- Acknowledge conflicts of interest, if any.

Abstract
- State the problem/question/objectives under investigation.
- Indicate the study design, including types of participants or data sources, and analytic strategy, main results/findings, main implications/significance.
- Identify five keywords.

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- Consider describing your approach to inquiry when it will facilitate the review process and intelligibility of your paper. If your work is not grounded in a specific approach to inquiry or your approach would be too complicated to explain in the allotted word count, however, it would not be advisable to provide explication on this point in the abstract.

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- Frame the problem or question and its context.
- Review, critique, and synthesize the applicable literature to identify key issues/debates/theoretical frameworks in the relevant literature to clarify barriers, knowledge gaps, or practical needs.

Guidance for Reviewers
- The introduction may include case examples, personal narratives, vignettes, or other illustrative material.

Study Objectives/Aims/Research Goals
- State the purpose(s)/goal(s)/aim(s) of the study.
- State the target audience, if specific.

Guidance for Authors
- If relevant to objectives, explain the relation of the current analysis to prior articles/publications.

Guidance for Reviewers
- Qualitative studies often legitimately need to be divided into multiple manuscripts because of journal article page limitations, but each manuscript should have a separate focus.
- Qualitative studies tend not to identify hypotheses, but research questions and goals.

Method
Research Design Overview
- Summarise the research design, including data-collection strategies, data-analytic strategies, and, if illuminating, approaches to inquiry (e.g., descriptive, interpretive, feminist, psychoanalytic, postpositivist, critical, postmodern, constructivist, or pragmatic approaches).
- Provide the rationale for the design selected.

Guidance for Reviewers
- Method sections can be written in a chronological or narrative format.
— Although they provide a method description that other investigators should be able to follow, it is not required that other investigators arrive at the same conclusions, but rather that their method should lead them to conclusions with a similar degree of methodological integrity.

— At times, elements may be relevant to multiple sections and authors need to organize what belongs in each subsection in order to describe the method coherently and reduce redundancy. For instance, the overview and the objectives statement may be presented in one section.

— Processes of qualitative research are often iterative versus linear, may evolve through the inquiry process, and may move between data collection and analysis in multiple formats. As a result, data collection and analysis sections might be combined.

— For the reasons above and because qualitative methods often are adapted and combined creatively, requiring detailed description and rationale, an average qualitative Method section typically is longer than an average quantitative Method section.
Record of email from contact at journal regarding paper length

Thu 11/04, 15:42
Hi Gayle,
Thank you for letting me know. Yes, this is definitely fine. When submitting your article to the journal please just indicate why your article is over the page limit within your cover letter.
Best,
Allison

Allison Gillens, MPS
Peer Review Coordinator, Publications & Databases
American Psychological Association

750 First Street NE, Washington DC 20002-4242

Thu 11/04, 14:46
agillens@apa.org <AGillens@apa.org>
Good afternoon Allison,
I am a trainee clinical psychologist at Queen's University Belfast. My research supervisor is Dr Lesley Storey.
I have a question regarding submission of a piece of research I have conducted. It is entitled:
The lived experience of OCD and religiosity: an interpretative phenomenological analysis.

This is an area that has had little research and a qualitative analysis of this type has not been conducted. The study highlights some new themes and experiences we did not previously know about. I am keen to publish in this journal as I feel it shall have relevance for clinicians and I found that the article published by yourselves by Himle (2011) was of great importance. This new research adds to our knowledge in the area.
I am currently submitting the research as part of my clinical psychology doctorate at Queen’s University Belfast. It should be no more than 36 pages, but as this is over your normal manuscript length I wanted to ask if you would still be interested. To cut this qualitative piece down would lose details regarding methodology, results and discussion. It can of course be cut but I feel it has more value with added detail.
I would appreciate your guidance in this matter.
Regards,
Gayle Hegarty
Trainee Clinical Psychologist
Queen’s University Belfast
Section 7: Ethics and governance approval

23 April 2018

Dr Lesley Storey
School of Psychology, David Keir Building
18-30 Malone Road
Belfast
BT9 5BN

Dear Dr Storey


REC reference: 18/NI/0043
IRAS project ID: 239768

Thank you for your letter of 19 April 2018, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair Professor Patrick Murphy.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

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

Conditions of the favourable opinion

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

Providing Support to Health and Social Care
Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise). Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdfforum.nhs.uk.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

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

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).
Approved documents

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

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<tr>
<td>Confirmation of any other Regulatory Approvals (e.g. CAG) and all</td>
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<td>19 April 2018</td>
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<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [ldeemity]</td>
<td>v1.0</td>
<td>04 February 2018</td>
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<td>Interview schedules or topic guides for participants [Interview Schedule]</td>
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<tr>
<td>Letters of invitation to participant [Reminder letter]</td>
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<td>Other [Info for Clinicians]</td>
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<td>Other [Debrief sheet]</td>
<td>v1.0</td>
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<td>Other [Risk/distress Protocol]</td>
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<tr>
<td>Other [Projected Timetable]</td>
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<td>Other [Info for Clinicians]</td>
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<tr>
<td>Participant consent form [Consent Form]</td>
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<td>04 February 2018</td>
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<tr>
<td>Participant information sheet (PIS) [PIS]</td>
<td>v1.0</td>
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<tr>
<td>Referee’s report or other scientific critique report [Proposal approval</td>
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<td>Ethics and Scientific Review]</td>
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<tr>
<td>Research protocol or project proposal [Protocol]</td>
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<td>Summary CV for Chief Investigator (CI) [LStoreyCV]</td>
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<td>Summary CV for student [GHegartyCV]</td>
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<tr>
<td>Summary CV for supervisor (student research) [DRogersCV]</td>
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<tr>
<td>Summary CV for supervisor (student research) [KDyerCV]</td>
<td>v1.0</td>
<td>04 February 2018</td>
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Statement of compliance

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

After ethical review

Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
• Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

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

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

18/NI/0043 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project.

Yours sincerely

[Signature]
P.P.

Professor Patrick Murphy
Chair

Email:recb@hscni.net

Enclosures: “After ethical review – guidance for researchers” [SL-AR2]

Copy to: Ms Paula Tighe
Ms Frances Johnston, Research Governance Manager, NHSCT
Research Office
Section 8: Reflective Appendix

Over the three years, a process of learning and application has taken place. This was the first time I had conducted qualitative research, or a systematic review. The over-arching theme for me has been around ownership and responsibility. This has been experienced in several ways; simply by both research projects being my own ideas and areas I am interested in, but also in how I interviewed participants, learned to conduct IPA analysis and interpretation and in my plans to disseminate the findings. The process has required a huge amount of independent learning and has highlighted several strengths to me, as well as highlighting how I deal with setbacks in research.

Ownership and responsibility:

My large-scale research project was pitched (in part) at a research fair and I contacted the clinical psychologist to discuss it further. There had been a few ideas that a qualitative project on OCD might be useful but there were no firm proposals. In a sense the ownership of the project transferred to me at this point. I had been curious about the phenomena of OCD and religiosity for several years following a lecture on OCD. Once it was agreed that I could develop this idea I felt that this was my project and that it mattered. This has been a huge strength for me and for the study, as it has helped galvanise me during difficult periods. Feeling ownership and responsibility for the project helped to push me forward. I had a real sense that these voices needed to be heard and that clinically, the research would have an impact.

Similarly, my systematic review was borne from my interest in my placement at the time. Working in a hospital setting in the community stroke team, I became aware of illness appraisals and posttraumatic growth. I was fascinated in the concept of positive change after trauma, as clinical psychology could have a real impact in this work. I also realised that the cardiac service within the hospital were developing a psychology service. I viewed the systematic review as an opportunity to find a gap in the literature whilst learning about an area I was interested in. Again, the focus on correlates of posttraumatic growth is important when considering clinical work and service development. So, the research has felt very relevant and personal for me and that has bolstered my efforts.

Interviewing participants:

Research is difficult. From conception, submitting a proposal, seeking ethical approval, conducting the research, analysing data and then writing it all up, there are many hurdles and low points. Personally, whilst I was nervous, I was looking forward to the process of interviewing participants for my large-scale research. It felt like the most important aspect of the study. Therefore, there was a lot of responsibility on my shoulders to use appropriate prompts and follow-up questions to elicit the lived experience. It was essential that I could use my skills and personal characteristics to make individuals feel comfortable during the process.
Feedback on my interviewing skills was extremely important to me. Given that clinical therapeutic skills are my day to day modality, it was essential I did not slip into that role. My supervisors were constructive, and I learned that there was a freedom in IPA. This really helped me to relax into interviewing and I developed in the first few interviews. I learned it was appropriate to go further into one area if I felt the participant had more to say. At one point my supervisor said she had an emotional reaction to a transcript, and this was a sign of a good interview.

Analysis

Becoming steeped in the data by listening to the audio transcripts several times and then reading it several times before beginning to code helped me focus on what I was hearing. I sought advice from my supervisor as I was unsure of how the process of coding was conducted. The book I was using to guide me gave coding examples for small n studies, but I was aware my study was with ten papers. Smith et al (2009) advise that when working with more than six interviews, the analysis cannot be as deep. In addition, the research question focussed the coding on the interaction of the phenomena (Braun and Clarke, 2013) as opposed to all information regarding OCD, or all information regarding religiosity. So, whilst the coding was complete, it was clearly focussed on the relationship and this helped me move from descriptive to a deeper level.

Dealing with Challenges and Setbacks

One part of my research journey involved dealing with a major setback. It required a re-write of my systematic review. The process was isolating and difficult, I noted how I moved between feeling energised and motivated, to ruminating, feeling that I could not progress and feeling unsupported. At this point my ability to write was severely diminished and this in turn confirmed my deepest fears about my ability.

This process included recognising my own blind-spots and my reticence to ask questions. Gradually I began to adopt strategies that work for me, such as planning and deadlines. I used supervision meetings to ask for more help and explain how I needed to set these short-term targets. I received valuable feedback from various sources and was able to hone my work. There was a huge change in my ability to sustain concentration and work. It has been difficult but so worthwhile. I now feel connected to my work at a much deeper level. The process is ongoing. Reflection shall be easier as time progresses, but these are my preliminary thoughts as I move towards viva.

Dissemination of Research

I see this as my next challenge and opportunity to learn. Certainly, to publish the study will be my main short-term goal and I have submitted both papers to two journals and have received requests to make some amendments and re-submit. Once I have done this I can speak to my supervisors and colleagues about next steps in dissemination. I have arranged to present to the Health Trust service user forum and to the Psychological Therapies Services
next team development day. I would like to present the research at an appropriate conference, but as I have been absorbed in analysis and writing up the research, I haven’t given this much thought. Essentially, my view is that by conducting the research I have been tasked to ensure the participants’ voices are heard.

Looking forward, by taking ownership and responsibility within my own research (whilst consulting with others), I am modelling a purposeful way to develop as a clinical psychologist post-qualification. Research is not just about showing leadership and working independently, it requires energy and motivating forces. It also requires the ability to ‘not know’ and ask for help. Both studies have provided many useful experiences which I will hopefully take into my future career.

References
