RELIGIOUS COPING AND DEPRESSION

Thesis submitted for the degree of
Doctor of Psychology
at the University of Leicester

by

Azmaira Mawji
Department of Neuroscience, Psychology and Behaviour
University of Leicester

2016

Declaration

I confirm that this research is my original work. It has been submitted in partial fulfillment for the degree of Doctor of Psychology and no part of it has been submitted for any other degree or academic qualification.

.....

Azmaira Mawji

Religious Coping and Depression
Azmaira Mawji

Research Abstract

Literature Review: A systematic review was conducted that evaluated the impact of religious coping on levels of depression among adults. The findings of the review supported a dichotomous view of the impact of religious coping on depression, and suggested that individuals who make use of positive religious coping methods experience significantly different levels of depression than those who use negative religious coping methods. Future research is needed to examine long-term effects of using positive and negative religious coping, to better understand how religious coping is used in non-Christian communities around the world.

Research Project: The current study investigated religious coping and depressive symptoms in the context of the Ismaili Muslim religious community in Nairobi, Kenya. Six participants were interviewed using semi-structured interviews and the data was analyzed using Interpretive Phenomenological Analysis (IPA). Four super-ordinate themes and twelve sub-ordinate themes emerged from the interviews. Overall, the findings indicated that religion appears to have both positive and negative influences on depressive symptoms, a finding that is generally supported by the wider literature on religious coping. Clinical implications for practice, limitations and areas for future research are discussed in relation to these findings.

Service Evaluation: The current study examined professional development within the context of the Community Counselling Services (CCS), local, community-based institution which provides voluntary counselling services for the Ismaili Muslim community. In the current study, counsellors' perspectives of the professional development trainings and the extent that these trainings improve their therapeutic practice and skills were explored. The findings indicated that while the counsellors experienced a broader scope of knowledge and positive client outcomes and service delivery, the trainings were often too theoretically-orientated and lacked sufficient practical components. These findings, together with recommendations for improvement are reported with consideration of the existing literature.

Acknowledgments

I would like to sincerely thank my supervisor, Dr. Stephen Melluish, for all your support, supervision, help and unending patience throughout this process. You have been tremendously helpful at every stage of this degree. I would also like to thank the participants who took time out of their busy schedule to participate in this study.

Word Count

Critical Literature Review	6,642
Research Project	14,305
Critical Reflection	2,014
Service Evaluation	5,990
Appendices	841
Total Word Count for Main Text	28,951
Total Word Count with Appendices*	29,792

*Word count excludes tables, mandatory appendices and references, as outlined in the PsyD Guidelines 2014-2015.

List of Contents

List of Tables

List of Figures

Part A Critical Literature Review

Part A: Critical Literature Review

The Relationship between Religious Coping and Levels of Depression: A systematic review

Abstract

Over the last few decades, clinicians and researchers have observed that religion is a complex, multi-functional phenomenon that impacts an individual's psychological, social, physical, and spiritual functioning. More recently, a growing interest in the field of religious coping and its implications for health and well-being has emerged. This review evaluated the relationship between religious coping and levels of depression among adults. A scoping search was carried out utilizing 11 databases. These were PsychInfo, PsychArticles, PsychExtra, Medline, Cochrane Database of Systematic Reviews, Applied Social Sciences Index and Abstracts (ASSIA), Social Service Abstracts, Sociological Abstracts, Web of Science, SCOPUS and Google Scholar. Manual searches of references of key reviews and studies were also carried out. Following the application of the inclusion and exclusion criteria, eleven studies were deemed appropriate for inclusion in this review. The studies all used quantitative methodology and used cross-sectional designs. The overall findings support a dichotomous view of the relationship between religious coping and depression, and suggest that individuals who make use of positive religious coping methods experience significantly different levels of depression than those who use negative religious coping methods. Regarding positive religious coping, four studies showed that it reduced levels of depression, five demonstrated that it was unrelated to depression, and two studies revealed mixed impacts. However, all eleven studies consistently showed that the use of negative religious coping methods was significantly and inversely related to depression levels. Future research is needed to examine long-term effects of using positive and negative religious coping, to better understand how religious coping is used in non-Christian communities around the world and to explore if the same findings are observed when depression levels are held constant.

Target journal: The British Journal of Clinical Psychology

1. Introduction

According to Koenig, King, and Carson (2012), most researchers agree that religion involves a specified set of beliefs, particular practices and certain rituals that are all related to the sacred. There are several dimensions of religion such as religious affiliation, religiosity, organizational and non-organizational religiousness, religious involvement, religious participation and religious coping. A major set-back is that most of these constructs have not been defined by a single author, but rather, have been variously operationalized by different researchers (Hill & Pargament, 2003; Idler et al., 2003; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; McFadden, 1995; Stolzenberg, Blair-Loy, & Waite, 1995). However, one of these terms, religious coping, was originally defined by a single author, Kenneth Pargament. This dimension of religion has received significant attention over the last two decades with several investigations being conducted on its impact on health and well-being (Koenig et al., 2012). Since the focus of the current literature review is on religious coping, Pargament's definition will be used to define and understand this construct.

1.1 Religious Coping

Religion as a source of comfort, strength and coping during times of adversity has gained increasing interest among social science and medical researchers. While several conceptualizations of religion have been developed and used in various studies, the most widely used is that of Kenneth Pargament. Pargament (1997) defined religion as "a search for significance in ways that relate to the sacred" (Pargament, 1997, p.32), and defined coping as a search for significance in times of stress" (Pargament, 1997, p.90). He therefore operationalized religious coping as "the use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Koenig, Pargament, & Nielsen, 1998, p. 513). Pargament developed a few models which encompassed religious coping including functions of religion, conceptualizations of religion and spirituality, and religious coping measures. For instance, when developing religious coping methods, Pargament first identified five key functions of religion in everyday living and in crisis. These were *Finding Meaning*, *Gaining Control*, *Gaining Comfort and Closeness to God*, *Gaining (religious) Intimacy with Others*, and

Achieving Life Transformation. He then developed a set of religious coping methods that reflected each of these five functions (Pargament, Koenig, & Perez, 2000). What he noticed in his research, however, was that religious coping was simply another way of coping, and therefore, it could be constructive or destructive, positive or negative. After investigating this further, Pargament identified two patterns of religious coping with potential implications for health. These were positive religious coping and negative negative religious coping.

He described positive religious coping as a way of coping that demonstrated a positive and supportive relationship with God, spiritual connection with God and with others, and a belief that life has meaning. He described negative religious coping as a way of coping that expressed a more insecure connection with God, as having beliefs of an ominous view of the world, and experiencing struggles when searching for significance in life (Pargament & Raiya, 2007). Using this new research, he developed positive and negative religious coping methods, which still reflected the five functions of religion, and compiled them into comprehensive measure called the Religious Coping Questionnaire (RCOPE). The RCOPE is currently the most widely used measure for religious coping, and numerous studies have established its reliability and validity (Khan & Watson, 2006; Pargament et al., 2000; Pargament, Feuille, & Burdzy, 2011; Tarakeshwar & Pargament, 2001).

Although Pargament's research on religious coping primarily focuses on religion, certain aspects also include spirituality. He described spirituality as a search for the sacred. This search takes place in a larger religious context, and is a process through which people seek to explore the divinity of whatever they hold sacred in their lives. He described the sacred as representing a supreme power that guides individuals in adaptive ways (Faigin, Pargament, & Abu-Raiya, 2014). It includes concepts such as God, the divine, ultimate reality, as well as any other aspect of life that takes on extraordinary nature due to its relation with such concepts. An important feature of Pargament's conceptualization of spirituality is that it is related to, and not independent of, religion (Hill & Pargament, 2008). Working with this conceptualization, Pargament realized that some of the religious coping methods which express an attempt to gain closeness with God may also reflect a spiritual function of searching for the sacred. Recognizing this, he developed additional religious

coping methods which reflected this spiritual element and included them in the RCOPE. It is important to note that although Pargament's work on religious coping is extensive, his studies are largely embedded within a Judeo-Christian understanding of a divine entity and measures such as the RCOPE reflect this.

1.2 Religious Coping and Depression

In cross-sectional and longitudinal studies, the use of religious coping has been associated with a number of mental health indicators such as happiness, anxiety, positive affect, and life satisfaction (Bhui, King, Dein, & O'Connor, 2008; Loewenthal, Cinnirella, Evdoka & Murphy, 2001). However, studies that specifically examine the relationship between religious coping and depression are fewer and the findings tend to be mixed. For example, some studies have shown religious coping to be inversely associated with depression (Eliassen, 2013; Heo, 2013; Taylor, Chatters, & Abelson, 2012). Other studies have found no relationship between religious coping and depression. For example, Kohn-Wood, Hammond, Haynes, Ferguson and Jackson (2012) investigated the relationship between three religious coping styles and depressive symptoms among US college students, and found that only non-religious coping methods were inversely associated with depressive symptoms. Other researchers have corroborated this finding (Ai, Huang, Bjork, & Appel, 2013; Tarakeshwar & Pargament, 2001). Still other studies have found that some forms of religious coping can increase levels of depression (Braam et al., 2010). Although these studies shed light on the relationship between religious coping and depression, a major limitation is that they do not use a consistent measure to assess it. This makes it challenging to draw firm conclusions about its overall relationship with depression.

Other studies have suggested that the impact of religious coping on depression is determined by the religious coping method used. However, these findings, also, tend to be mixed. For example, one finding is that the use of positive religious coping strategies is associated with lower levels of depression, while the use of negative religious coping strategies is associated with higher rates of depression (Cole, 2005; Davis, Ashby, McElroy, & Hook, 2014; Pargament & Raiya, 2007). Other studies indicate that only negative religious coping is related to levels of depression, while positive religious coping is

unrelated to depression (Krumrei, Mahoney, & Pargament, 2011; Leaman & Gee 2012; Sherman, Simonton, Latif, Spohn, & Tricot, 2005; Trevino et al., 2010). Additionally, one longtitudinal study found that negative religious coping precedes and even causes depression (Pirutinsky, Rosmarin, Pargament, & Midlarsky, 2011).

There were no meta-analyses found to specifically examine religious coping and depression. However, two meta-analyses and four reviews were found to focus on religious coping and mental health, one aspect of which was depression. The first meta-analysis revealed that positive religious coping was mildly related to reduced depressive symptoms, while negative religious coping was more strongly related to higher levels of depressive symptoms (Smith, McCullough, & Poll, 2003). The second meta-analysis found that positive religious coping was related to positive adjustment to stress and inversely related to negative adjustment. Additionally, that negative religious coping was unrelated to positive adjustment but was positively related to negative adjustment (Ano & Vasconcelles, 2005). The earliest review reported that the lowest rates of depressive symptoms were associated with positive religious coping, and that increased depressive symptoms were associated with negative religious coping (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001). The second review noted that positive religious coping has been consistently and positively related to desirable mental health indicators, such as reduced anxiety, depression and post-traumatic stress symptoms, and increased optimism and relations with others, whereas negative religious coping has been related to more detrimental mental health outcomes, such as decreased feelings of hope, and increased post-traumatic stress symptoms, anger and distress (Pargament & Abu-Raiya, 2007). A third and more recent review also noted that positive religious coping was linked to lower depression and negative religious coping was linked with higher depression (Abu-Raiya & Pargament, 2015). In the fourth and most recent review, Cummings and Pargament (2010) found similar results among patients with various medical conditions such as heart failure, cancer, diabetes, and HIV/AIDS.

Although the results of these reviews highlight important findings regarding the complex relationship between religious coping and depression, there are several limitations. First, the studies do not use a consistent definition of religious coping, nor do they all measure it the same way. Second, none of the meta-analyses focus exclusively on

depression, but rather, explore it as one of several mental health indicators in relation to religious coping. Third, the most recent meta-analysis was published in 2007, which excludes important studies of non-Christian religious coping measures that were published after 2007. The purpose of the current literature review, therefore, is to evaluate studies published in the last 10 years that examine the relationship between religious coping and depression, to synthesize the findings, and provide a more recent and comprehensive overview of research in this area.

2. Method

A critical and systematic review of the literature on the impact of religious coping on depression was conducted using eleven electronic databases. These were PsychInfo, PsychArticles, PsychExtra, Medline, Cochrane Database of Systematic Reviews, Applied Social Sciences Index and Abstracts (ASSIA), Social Service Abstracts, Sociological Abstracts, Web of Science, SCOPUS and Google Scholar. These databases were selected as they would enable access to a wide scope of available information, including journals from a medical perspective, psychological perspective, and those made available to the general public, such as through Google Scholar. Searches were conducted using combinations of the terms 'depression', 'depressive', 'depressed' and 'religious coping'. In order to ensure that all potential studies were identified, the reference sections of relevant articles as well as previous reviews were hand searched.

The following inclusion criteria were applied: Quantitative and qualitative papers aiming to evaluate the relationship between religious coping and depression among an adult population (18+ years). Studies utilizing a measure of religious coping that was developed by Pargament, or an adaption of it. Studies that were further required to be in peer-reviewed, English language journals and published between 2005 and 2015. The reason for selecting only measures developed by Kenneth Pargament was because his definition and measure of religious coping are both currently the most widely used in research studies (Aflakseir & Coleman, 2011). The use of Pargament's religious coping measure also ensured that all articles operationalized religious coping in the same way, which enabled more accurate study comparisons. The 10-year time frame was selected to ensure that most recent literature was examined. The inclusion of qualitative and quantitative allowed the researcher to gain both insight and numerical data on the relationship between religious coping and depression.

The following exclusion criteria were applied: Reviews, books, and purely discursive papers were excluded. Articles that examined medical, psychiatric or other psychological diagnoses in addition to depression were excluded. Studies that examined specific types of depressive disorders which developed under unique circumstances, such as psychotic depression and postpartum depression, were excluded. Articles that solely investigated

spirituality, mysticism, transcendental experiences, and spiritual struggles were excluded, as were those that focused exclusively on only one religious coping method. The reason for only selecting articles that focused solely on depression, the onset of which was not due to unique circumstances, was to ensure that every article was as relevant to the review question as possible, which would in turn enable more accurate study comparisons. Additionally, concepts such as spirituality, mysticism, transcendental experiences, and spiritual struggles are noted to be conceptually different from religious coping (Koenig et al., 2012). Further, articles that examined only one religious coping method would limit the ability to make accurate study comparisons.

A systematic search of the databases was first conducted to find articles that included a majority of the search terms listed above, in the abstracts or titles. These initial searches resulted in a total of 616 articles, including four articles that were found from reference sections of relevant articles. 16 duplicates were first removed. Next, initial screenings were conducted, which involved reading titles and abstracts to check for relevance to the review question, using the inclusion and exclusion criteria described above. A total of 95 articles were initially screened in this way, from which 46 articles were found to be relevant, and 49 articles were found to be irrelevant. More in-depth reviews were then conducted on the 46 articles. This involved looking more carefully and thoroughly through the article content to determine whether or not the article matched the review question and was appropriate to be included in the current review, using the inclusion and exclusion criteria. After this in-depth screening, 35 articles were deemed not to be appropriate and were removed on one or more grounds (See Appendix A). Figure 1 displays a visual flow chart to further clarify the article screening and selection process (Figure 1). The 11 articles that remained were included in this review and were deemed to be exhaustive of the most recent research available on the subject area. Although one of the 11 articles (Tarakeshwar et al., 2003) was published in 2003, it was felt that due to its focus on cross-cultural research and being the only one of its kind to examine religious coping among a Hindu population, as well as due to limited research available in the area of religious coping and depression, it was acceptable to be included in the current review. Following the selection of the 11 articles, a systematic review for each article was conducted examining its aims, sample population,

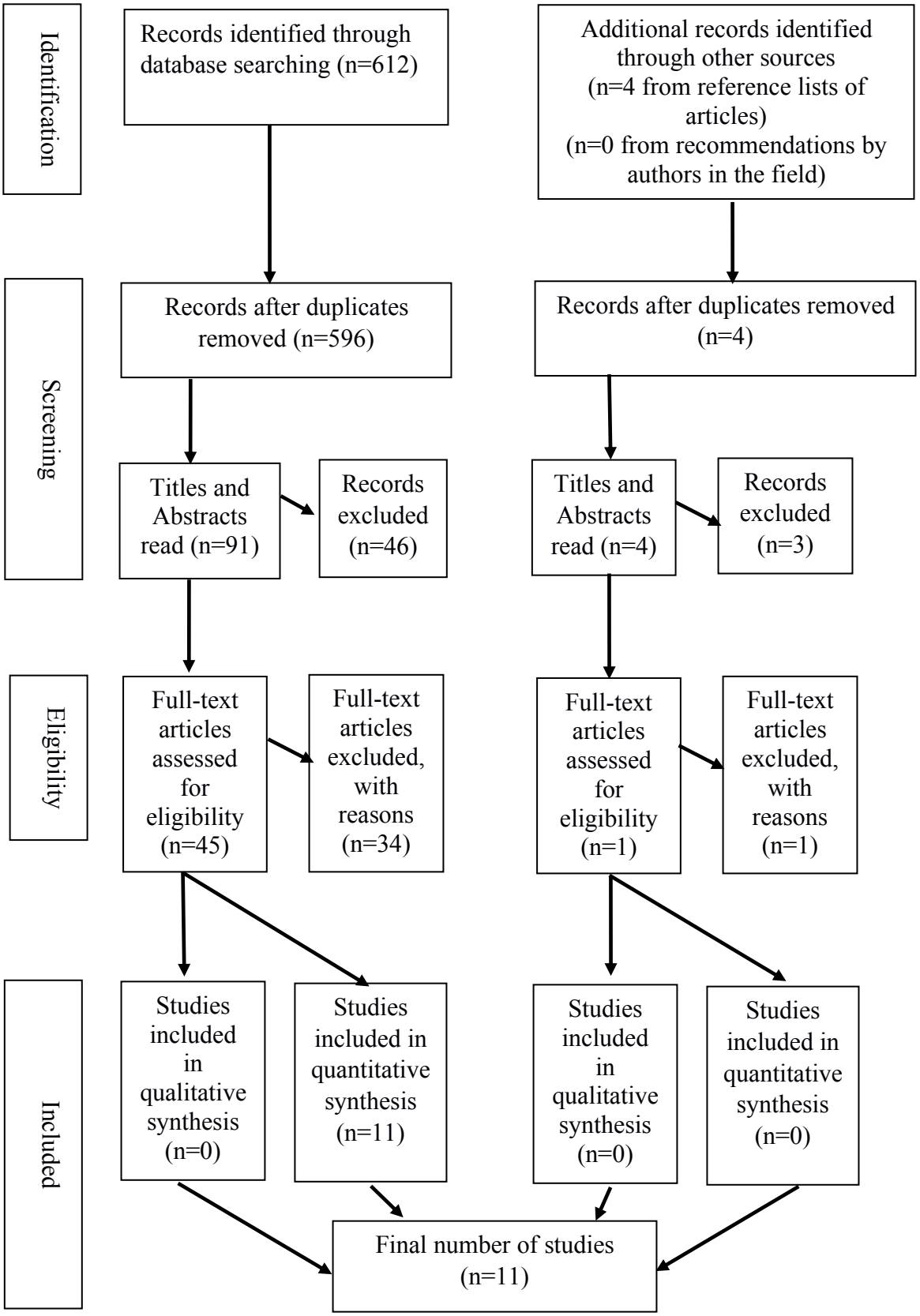
methodology, outcome measures, reliability and validity, and limitations, using a data extraction form (see Appendix B).

2.1 Quality Appraisal

The 11 papers were also appraised for quality and methodological rigour using the Critical Appraisal Skills Programme (CASP). CASP tools help a researcher to assess the trustworthiness, relevance and results of published papers ("Critical Appraisal," 2013). Since CASP does not provide a quality appraisal tool for cross-sectional studies, the tool for cohort studies was seen as the next best option. Since the 11 studies focused on groups of individuals with similar characteristics, such as divorced individuals, or individuals from a particular religion, it was concluded that this appraisal tool would largely be able to appraise the 11 studies. Cohort, cross-sectional, and case-control studies are collectively referred to as observational studies. These types of studies are often the only practical methods of researching various problems, such as studies of aetiology, instances where a randomized controlled trial might be unethical, or if the condition to be studied is rare. Cross-sectional studies are used to determine prevalence. They are relatively quick and easy but do not allow a distinction to be made between cause and effect (Yang et al., 2010). Cohort studies are used to study incidence, causes, and prognosis, and since they measure events in chronological order they can be used to distinguish between cause and effect.

The CASP tool for cohort studies appraised for quality in 13 areas. These included addressing a clearly focused issue, using appropriate recruitment methods that minimized selection bias, using measurement tools that minimize bias, identifying and considering confounding factors, appropriate follow-up of subjects, reporting of confidence intervals, whether the researcher believes the results, applicability of results, the fit between the results and available evidence, and implications for practice. In summary, all studies demonstrated adequate quality and had no major quality issues. They were therefore all included in the current review (see Appendix C for a summary of the CASP quality appraisal of the 11 studies). The results of the 11 studies are synthesized and reported below.

Figure 1: Flow Chart



3. Results

All studies looked at the relationship between religious coping and levels of depression, with the types of depression varying in some articles. While the definitions and measurement of religious coping was consistent in all studies, the sample populations and the religious affiliations reported varied significantly. The pooled sample consisted of a total of 14,084 participants. Of this, 57% percent identified themselves as White/Caucasian, 25% as Black, 4.5% as Mixed/Biracial/Other Races, 2.4% as Asian, 0.9% as Hispanic/Latino/a, 0.6% as African American and 0.2% as Asian American. Race was not reported for the remaining 9.4%. In regards to religious affiliation, 82.5% of the total sample identified themselves as Christian, 6.8% as Buddhist, 3.5% as Muslim, 3% as Jewish, 1.1% as Hindu, and .1% as 'other'. No particular religious affiliation (or lack thereof) was specified for the remaining 3% of the sample. Nine of the studies were conducted in the United States, one in Amsterdam and one in Pakistan.

The findings from the eleven studies did not indicate a single, overall conclusion on the relationship between religious coping and depression. Rather, the results were all dichotomous, revealing significantly different relationships between religion and depression depending on whether positive or negative religious coping was used. For the purposes of clarity, the results section has been structured according to the relationships found.

3.1 Positive Religious Coping is Related to Lower Depression Levels, and Negative Religious Coping is Related to Higher Depression Levels

Four studies fit this category (Krumrei, Pirutinsky, & Rosmarin, 2013; Phillips, Michelle-Cheng, Oemig, Hietbrink, & Vonnegut, 2012; Rosmarin, Pargament, Krumrei, & Flannelly, 2009; Webb et al., 2010). Two studies aimed to develop a measure of religious coping that applied to non-Christian religions, specifically Buddhism for Phillips et al.'s (2012) study and Judaism for Rosmarin et al.'s (2009) study, and correlate them with several adjustment measures, including depression. The third study examined the effects of recent divorce and religious coping on depressive symptoms (Webb et al., 2010), and the fourth study examined the relationship between religious coping and depressive symptoms using the Jewish Religious Coping Scale (Krumrei, 2013). Rosmarin et al. (2009) studied a sample which included individuals aged 15 years. Although this met the exclusion criteria

for age, it was felt that due to its unique focus of examining a religious coping measure among Jews, and due to limited research available in this area, it would be included in the review.

The total sample was highly varied, ranging from 208 to 10,988 and the total number of participants was 12,299. Of these, 10,988 were Christian, 869 participants were Buddhist, 442 were Jewish, and 99% resided in North America. Additionally, 63% were Caucasian, 29% were Black, 5% was mixed/biracial/other races, 0.4% Asian and 0.2% was Hispanic. Race was not reported or specified for the remaining 2.4% of the participants. Education levels were not reported for this sample.

3.1.1 Study procedures.

Three studies (Krumrei, 2013; Phillips et al., 2012; Rosmarin et al., 2009) used internet-based methods to recruit their participants, with two studies using word of mouth as an additional aid to recruitment. The fourth study primarily used organized information sessions conducted by pastors and selected Church members at thousands of Churches (Webb et al., 2010). All studies gathered data for their investigations using self-report surveys and questionnaires.

3.1.2 Outcome measures relevant to religious coping and depression.

Different versions and adaptations of Pargament's religious coping scale were used. For example, Webb et al. (2010) used the Brief Religious Coping Scale (Brief RCOPE) (Pargament, Smith, Koenig, & Perez, 1998), which is a 14-item measure of religious coping that assesses positive and negative religious coping, respectively. It has shown to have good internal consistency, as well as good concurrent, predictive and incremental validity (Pargament, Feuille, & Burdzy, 2011). Phillips et al. (2012) used the Buddhist Coping Scale (BCOPE), which is a Buddhist-specific coping scale that reflects ways which individuals might draw on 17 different Buddhist beliefs and practices to cope with life difficulties. Rosmarin et al. (2009) and Krumrei (2013) used the Jewish Religious Coping Scale, which is a 16-item scale that assesses the use of Jewish religious beliefs and practices when dealing with stress.

To measure depression, three studies administered the Center for Epidemiological Studies–Depression (CES-D) while Phillips et al. (2012) used the depression subscale of the Brief Symptom Inventory (BSI) (Derogatis & Melisaratos, 1983). The CES-D scale (Radloff, 1977) is a widely used 20-item scale that measures several aspects of depression. The scale has been shown to be internally consistent, has demonstrated content, criterion-related, and construct validity in addition to good sensitivity and specificity. The BSI is a short version of the Symptom Checklist 90-Revised, and is a 53-item inventory covering clinically relevant psychiatric and psychosomatic symptoms.

3.1.3 Results of the studies.

It was consistently found through the studies within this category that positive religious coping was associated with reduced levels of depression and negative religious coping was associated with increased levels of depression. For example, in Phillips et al.'s (2012) study, all positive religious coping methods were inversely related to depression, of which four were significant. The method which had the strongest association to depression was *Impermanence* (β= -0.16, p<.001), or realizing that most things change. This method belonged to Pargament's religious function of *Finding Meaning*. In contrast, negative religious coping was found to be significantly, positively related to depression and the method which had the strongest association was *Bad Buddhist* (β=0.38, p<.001), or believing that one has failed to live up to Buddhist principles. This method belonged to the religious function of *Gaining Comfort and Closeness to God*.

Webb et al. (2010) also observed that positive religious coping was inversely associated with depressive symptoms for individuals who divorced within the past 5 years. Three specific methods all had the strongest associations to depression. The first was *Seeking support from God* ($\beta = -.123$, $p < .001$) which belonged to the religious function of *Gaining Comfort and Closeness to God*. The second was C*ollaborative Coping*, or working together with God ($\beta = -.103$, $p < .001$), which belonged to the religious function of *Gaining Control*. The third method was *Benevolent Reappraisal*, or reframing troubling events ($\beta = -.078$, $p < .001$), which belonged to the religious function of *Finding Meaning*. In contrast, negative religious coping was positively related to depression ($\beta = .278$, $p < .001$), but did not exacerbate the deleterious effects of divorce on mental health.

In Rosmarin et al.'s (2009) study, Jewish individuals who used positive religious coping methods reported lower levels of depression ($r= -0.19$, $p<.01$), and the inverse was true for negative religious coping ($r=0.34$, $p<.01$). Negative religious coping was also a significant predictor of depression ($\beta= 0.32$, $p<.001$). Krumrei (2013) found that not only was positive religious coping significantly, inversely related to depressive symptoms ($R= 0.26$, $p<0.01$) but it also predicted higher rates of depression. The opposite was true for negative religious coping ($R= 0.38$, $p<0.01$). These results clearly provides support for this interesting pattern of relationships between religious coping and depression and suggests that this finding applies to Jewish, Buddhist and Christian religious groups.

3.1.4 Limitations and methodological issues.

One of the main limitations is that all measures used were self-report, which could artificially inflate the association between the religious coping measures and measures of depression. Further, since all studies used a cross-sectional design, causal inferences as well as determination of the direction of influence cannot be made. Additionally, the majority of the studies used recruitment methods primarily involving online means which potentially excludes individuals who may not have access or have limited access to the internet.

3.2 Positive Religious Coping is Unrelated to Depression Levels, but Negative Religious Coping is Related to Higher Depression Levels

Five studies fit this category of results (Falb & Pargament, 2013; Herrera, Lee, Nanyonjo, Laufman, & Torres-Vigil, 2009; Khan & Watson, 2006; Stein et al., 2013; Tarakeshwar, Pargament, & Mahoney, 2003). Two studies examined the relationship between religious coping and depression among care-givers, one using a Buddhist sample (Falb & Pargament, 2013) and one using a Christian sample (Herrera et al., 2009). The third study examined the relationship between religious coping and depression on young adults affected by the economic crisis in the United States (Stein et al., 2013), and the fourth study assessed the Pakistani Religious Coping Practices Scale and the Brief RCOPE among a Pakistani sample, and correlated both measures with mental health (Khan & Watson, 2006). The fifth study attempted to develop a Hindu Religious Coping Scale and correlate it with several measures of mental health (Tarakeshwar et al., 2003). Although this study was published in 2003, it was felt that due to its focus on cross-cultural research, being the only

one of its kind to examine religious coping among a Hindu population, and due to limited research available in this area, it would be included in the review.

The sample size ranged from 61 to 222 and the total number of participants was 673. Of this sample pool, 238 participants were Christian, 129 were Muslim, 164 were Hindu, 92 were Buddhist, and 50 reported no religious affiliation. Additionally, 40% of the participants identified themselves as Caucasian, 43% as Asian and 10% as Latino. Race was not identified for the remaining 7% participants. A high percentage of the sample pool (88%) was well educated, possessing at least one degree or enrolled in post high-school education.

3.2.1 Study procedures.

Two studies recruited participants through the university they attended (Khan & Watson, 2006; Stein et al., 2013), and the remaining three used a combination of telephone calls, email listservs, personal contact at religious places of worship, and training programs (Falb & Pargament, 2013; Herrera et al., 2009; Tarakeshwar et al., 2003). All studies gathered their data using self-report questionnaires and surveys.

3.2.2 Outcome measures relevant to religious coping and depression.

Tarakeshwar et al. (2003) used the Hindu Religious Coping Scale, which is a 20-item religious coping measure that incorporates specific tenets of Hinduism. It has demonstrated good reliability and validity (Tarakeshwar et al., 2003). Falb and Pargament (2013) used the BCOPE, and Khan and Watson (2006) used the Pargament's Brief RCOPE as well as the Pakistani Religious Coping Practices Scale. The latter is an 8-item measure that includes components of Islamic religious behaviors and beliefs, and does not report the inclusion of negative coping methods. The remaining two studies also used the Brief RCOPE, one of which (Stein et al., 2013) only assessed the meaning-making subscales. Four studies used the CES-D and one used the depression subscale of the BSI.

3.2.3 Results of the studies.

For this category, the results consistently indicated that only negative religious coping was significantly related to levels of depression. For example, Falb and Pargament (2013)

found that while positive religious coping was unrelated to depression, negative religious coping was significantly, positively related (β= 0.33, where p<.01). In particular, the *Bad Buddhist* coping method, which belonged to the religious function of *Gaining Comfort and Closeness to God,* was the most strongly related. Stein et al. (2013) found that young adults who used positive religious coping strategies to help them cope with the U.S. economic crisis experienced no change in their levels of depression. However, those who used negative coping strategies, and, in particular, felt that the crisis was a *Punishment from God,* reported significantly higher levels of depressed mood (β = .18). This coping method belonged to the religious function of *Finding Meaning.*

Tarakeshwar et al. (2003) corroborated these findings and observed that Hindu individuals who used positive religious coping did not report any differences in their levels of depression. However, those who used religious coping strategies based on *Religious Guilt, Anger, and Passivity* experienced significantly greater depressed mood (β= .40, p ≤ .01). These strategies belonged to the religious functions of *Finding Meaning* and *Gaining Control*. Herrera et al. (2009) also noted that the use of negative religious coping significantly predicted higher depression (β=0.21, p<0.05). Khan and Watson (2006) found that neither the Pakistani Religious Coping Practices scale nor the positive religious coping subscale of the Brief RCOPE were correlated with depression. Although negative correlations were found between these variables after the variance associated with the negative religious coping subscale of the Brief RCOPE was removed, the correlations were only partial and weak. In contrast, the use of negative religious coping methods from the Brief RCOPE was associated with significantly higher levels of depression (r=0.43, p < .01). The overall findings in this category are significant and highlight the detrimental effects of negative religious coping on one's level of depression, regardless of religion or race.

3.2.4 Limitations and methodological issues.

All measures were self-report which could artificially inflate the association between the religious coping measures and levels of depression. The significant variance in the time-frame and number of the stressors which participants were asked to focus on limits the ability to make fully accurate comparisons of the findings. Additionally, being asked to recall a past stressor may have introduced sources of error variance that lowered the

magnitude of observed relations. Also, the present reporting of coping could have been influenced by the time-frame of the stressor, how successful the person was/is in dealing with the stressor, and the number of stressors asked to think about at once.

3.3 Mixed Findings regarding the Positive Religious Coping, but Negative Religious Coping is Related to Higher Depression Levels

This category consisted of two studies (Bjorck & Thurman, 2007; Braam et al., 2010). Braam et al. (2010) sought to describe the relationship between religious coping and depressive symptoms, sub-threshold depression and Major Depressive Disorder (MDD), and Bjorck and Thurman (2007) investigated potential moderating effects of religious coping on the relationship between negative life events and psychological functioning.

The total number of participants in the sample pool was 1112. The sample in Braam et al.'s (2010) study consisted of native Dutch, Moroccan, Turkish and Surinamese/ Antillean (SNA) participants, and race was not reported for any of the participants. In Bjorck and Thurman's (2007) study, all participants were Christians, of which 39.3% were reported White, 28% African American, 13.7% Latino/a, 11% Asian American, and 8% 'others'. Of the total sample pool, there were 495 Christians, 387 Sunni Muslims, nine Hindus, ten as 'other', and 211 individuals without a religious affiliation. The education levels of the sample were low, with only 228 participants reporting post-high school education.

3.3.1 Study procedures.

Regarding recruitment, one of the studies used respondents of a second phase of a population based study on health (Braam et al., 2010), while the other recruited participants through the use of three large church directories (Bjorck & Thurman, 2007). Braam et al. (2010) gathered data for their study using personal interviews while Bjorck and Thurman (2007) mailed out questionnaires.

3.3.2 Outcome measures relevant to religious coping and depression.

Both studies used the Brief RCOPE to measure religious coping. Bjorck and Thurman (2007) measured depression with the CES-D while Braam et al. (2010) used the depression subscale of the Composite International Diagnostic Interview (CIDI). The CIDI is an

assessment of mental disorders according to the definitions and criteria of ICD-10 and the DSM-IV, and has demonstrated good reliability and validity (Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998).

3.3.3 Results of the studies.

Both studies indicated mixed findings, where the overall relationship between religious coping and depression was inconclusive. For example, Braam et al. (2010) found that positive religious coping was not significantly associated with MDD or depressive symptoms. However, for the SNA group, it was associated with an increase in depressive symptoms ($p=.016$ where $p<.05$), and, for the total sample, it was associated with higher sub-threshold depression. The study further reported that negative religious coping was significantly related to depressive symptoms, sub-threshold depression and MDD for the total sample, with four out of five coping methods having the strongest associations. These were *Punishment Reappraisal* ($\beta=0.14$; OR=1.29; OR=1.47), the *Abandonment Interpretation* ($\beta=0.2$; OR=1.54; OR=1.43), *Questioning the Existence of God* ($\beta=0.1$; OR=1.00; OR=1.48), and *Expressing Anger to God* ($\beta=0.12$;OR=1.37; OR=1.19) respectively, where $p<.05$. Further, the *Abandonment Interpretation,* which belonged to the religious function of *Gaining Comfort and Closeness to God,* showed the most consistent, positive association across the types of depression and ethnic groups.

Bjorck and Thurman (2007) also found mixed results. Initially, the authors found that positive religious coping was not significantly related to depression. However, after controlling for two covariates, which were questionnaire order and religious participation, not only was positive religious coping found to be inversely related to depression ($F(1,654)\geq3.74$, ps ≤0.05), it was also found to buffer the effects of negative life events on levels of depression. The study also found that negative religious coping was significantly related to increased depression ($r = 0.51$, $p < 0.001$), and that this was observed even after controlling for the same covariates ($F(1,654)\geq4.32$, $ps<0.05$). Although these results are inconclusive in regards to the overall relationship between religious coping and depression, they are important and point to the complexity in understanding this relationship, especially regarding non-Western cultures, religious traditions and ethnicities.

3.3.4 Limitations and methodological issues.

There are several limitations with both studies. In Braam et al.'s (2010) study, first, the participants were all self-selected and therefore, selection bias cannot be ruled out. Second, the use of the Brief RCOPE may not have appropriately measured religious coping for Muslim and Hindu participants. In Bjorck and Thurman's (2007) study, a low response rate of 27.1% may have reduced the statistical power. Secondly, the participants were asked to complete questionnaires for the past year, which may have introduced sources of error variance that lowered the magnitude of observed relations.

4. Discussion

The aim of this review was to synthesize and analyze research looking at the relationship between religious coping and levels of depression. The overall findings support a dichotomous view of this relationship and suggest that individuals who make use of positive religious coping methods experience significantly different impacts on depression than those who use negative religious coping methods, which is consistent with previous reviews (Pargament & Raiya, 2007). The results of the current review revealed that negative religious coping was significantly and inversely related to depression across all eleven studies, pointing to the clear detrimental effects of using this form of coping with depression. Further, this was observed across cultures, ethnicities, religions, adult age groups, and education levels, suggesting that the relationship between religious coping and depression may be universal.

The literature reviewed was inconclusive for positive religious coping. Specifically, four studies found it to reduce levels of depression, five showed it to be unrelated to levels of depression, and two studies revealed mixed findings. These findings can be interpreted to mean that this form of coping may not be as powerful in alleviating levels of depression. However, the four studies which consistently found it to reduce levels of depression were of people living in North American and also contained the highest sample of Christian individuals. Considering this, the findings above may also indicate that positive religious coping may not be well understood or assessed among non-Christian populations living outside of North America. It may also suggest that positive religious coping might be more congruent with Christianity in some way, given that it was largely developed and validated among Christian populations. Further research is needed to clarify these points.

The comparisons across studies were made possible by similarities among the eleven studies. For example, all eleven studies defined and measured religious coping the same way and eight studies measured depression using the CES-D. The studies also used quantitative methodology and cross-sectional designs. Despite these strengths, however, there were also several limitations and methodological issues which must be taken into account. For example, the severity of depression was not held constant and some studies only focused on certain subscales of the RCOPE. Additionally, examining studies that only

used the RCOPE or an adaption of it limits the generalizability of the findings. Further, all studies used a cross-sectional design so inferences regarding causality and direction of influence cannot be made, and the fact that none were longitudinal studies does not provide information on the long-term influences of religious coping on levels of depression. Additionally, variance in the number of the stressors participants were asked to focus on and the time they occurred in the participants' lives also indicate that comparisons should be made with caution. Also, although all studies were of good quality, some studies were of greater quality than others. For example, Bjorck and Thurman (2007), Krumrei, Pirutinsky and Rosmarin (2013), and Rosemarin, Pargament, Krumrei and Flannely (2009) conducted studies that were of greater quality than other studies as their sample populations were more generalizable, recruitment methods more effectively minimized biases, and limitations and study implications were more clearly outlined. However, the study by Khan and Watson (2006) was of less quality as the sample population was more biased and therefore less generalizable, and although confounding factors were considered in the analysis, they were not clearly identified.

From the studies that were reviewed, a closer look was taken at Pargament's functions of religion found to be most strongly associated with depression. Of the studies that elaborated on this, three out of the five were most commonly reported. These were *Gaining Comfort and Closeness to God*, *Finding Meaning* and *Gaining Control.* This observation provides a valuable insight about what people hope to gain out of using religion to cope with depression. It also suggests that methods belonging to the remaining two functions, *Gaining (religious) Intimacy with Others (in the community)*, and *Achieving Life Transformation,* may not be as important when trying to deal with depression.

A more in-depth inspection was carried out on the differences between the positive and negative religious coping methods used, and how they related to the five functions. It was found that the highest number of positive religious coping methods with the strongest correlations to depression belonged to the *Finding Meaning* function, and the remaining belonged equally to the *Gaining Comfort and Closeness to God* and *Gaining Control* functions. However, the highest number of negative religious coping methods with the strongest correlations to depression belonged to the *Gaining Comfort and Closeness to God*

function, the second highest belonged to the *Finding Meaning* function, and the third to the *Gaining Control* function. These findings suggest that people with depression who search for meaning from their experience also seem to experience lower levels of depression, while those who struggle with comfort and closeness with God experience higher levels of depression. These findings have important clinical implications, but cannot be generalized to all populations or cases of depression, especially since the direction of influence has not yet been determined.

Another point of discussion is the practicality of developing a generic measure of religious coping that can validly and reliably be applied across religions. For example, Bjorck and Thurman (2007) used the RCOPE and noted that two negative religious coping methods, *Doubting the Existence of God,* and *Expressing Anger to God*, were used minimally among Muslim participants. This may be due to the fact that certain cultures, such as Turkish and Moroccan, may not accept open criticism, anger or doubting God's existence, and therefore, this may be especially conflicting for a participant who has to answer this question on a measure. This example also brings to light the applicability of the RCOPE on Muslim participants, as some of the religious coping aspects identified by Pargament, such as *Collaborative Religious Coping*, *Seeking Control through a Partnership with God* and *Demonic Reappraisal*, are contrary to Islamic belief (Aflakseir & Coleman, 2011). In another example, Tarakeshwar et al. (2003) noted that certain religious coping methods represented coping strategies for Christians, but lifestyle practices for Hindus. These differences again highlight the question of whether it is possible to develop a single measure of religious coping that can be used with different religions and accurately capturing unique religious and spiritual differences across faiths, without compromising on validity.

In conclusion, the findings clearly highlight the relationships between religious coping on levels of depression, showing significantly different findings for positive and negative coping. Although these findings are limited, they have important clinical implications. In particular, the findings related to negative religious coping can be used to alert mental health professionals of religious red flags or signs of deteriorating coping when working with clients with depression. Although the findings regarding positive religious coping

suggest that they may work better for Christian clients living in North America, clinicians should still be cautious as the overall findings are not yet conclusive. In light of this, further research is needed to better understand how positive religious coping is used in non-Christian communities around the world, to develop interventions that may be used to help individuals shift from using negative to positive religious coping methods and to explore if the same findings are observed when depression levels are held constant. Longitudinal studies would also help ascertain if the findings noted from the current review can be observed in the long-term, and provide insight on the direction of influence, on whether levels of depression may also influence the kind religious coping methods used.

References

Abu-Raiya, H., & Pargament, K. (2015). Religious coping among diverse religions: Commonalities and divergences. *Psychology of Religion and Spirituality, 7*(1), 24.

Abu Raiya, H., Pargament, K., Mahoney, A., & Stein, C. (2008). A psychological measure of Islamic religiousness: Development and evidence for reliability and validity. *The International Journal for the Psychology of Religion, 18*(4), 291-315.

Aflakseir, A., & Coleman, P. (2011). Initial development of the Iranian religious coping scale. *Journal of Muslim Mental Health, 5*(1), 44-61.

Ahles, J., Mezulis, A., & Hudson, M. (2015). Religious coping as a moderator of the relationship between stress and depressive symptoms. *Psychology of Religion and Spirituality.* Advance online publication. http://dx.doi.org/10.1037/rel0000039

Ai, A., Huang, B., Bjorck, J., & Appel, H. (2013). Religious attendance and major depression among Asian Americans from a national database: The mediation of social support. *Psychology of Religion and Spirituality, 5*(2), 78.

Amer, M., Hovey, J., Fox, C., & Rezcallah, A. (2008). Initial development of the brief Arab religious coping scale (BARCS). *Journal of Muslim Mental Health, 3*(1), 69-88.

Andresen E., Malmgren J., Carter W., & Patrick D. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D. *American Journal of Preventative Medicine, 10*(2), 77–84.

Ano, G., & Vasconcelles, E. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*(4), 461-480.

Armento, M., McNulty, J., & Hopko, D. (2012). Behavioral activation of religious behaviors (BARB): Randomized trial with depressed college students. *Psychology of Religion and Spirituality, 4*(3), 206.

Bhui, K., King, M., Dein, S., & O'Connor, W. (2008). Ethnicity and religious coping with mental distress. *Journal of Mental Health, 17*(2), 141-151.

*Bjorck, J., & Thurman, J. (2007). Negative life events, patterns of positive and negative religious coping, and psychological functioning. *Journal for the Scientific Study of Religion, 46*(2), 159-167.

Braam, A., Schaap-Jonker, H., Mooi, B., Ritter, D., Beekman, A., & Deeg, D. (2008). God image and mood in old age: Results from a community-based pilot study in the Netherlands. *Mental Health, Religion & Culture, 11*(2), 221-237.

Braam, A., Schaap-Jonker, H., van der Horst, M., Steunenberg, B., Beekman, A., van Tilburg, W., & Deeg, D. J. (2014). Twelve-year history of late-life depression and subsequent feelings to God. *The American Journal of Geriatric Psychiatry, 22*(11), 1272-1281.

*Braam, A., Schrier, A., Tuinebreijer, W., Beekman, A., Dekker, J., & de Wit, M. (2010). Religious coping and depression in multicultural Amsterdam: A comparison between native Dutch citizens and Turkish, Moroccan and Surinamese/Antillean migrants. *Journal of Affective Disorders, 125*(1), 269-278.

Buser, J., Kearney, A., & Buser, T. (2015). Family, friends, and romantic partners of eating disorder sufferers the use of spiritual/religious coping strategies. *The Family Journal, 23*(4), 320-329.

Cole, B. S. (2005). Spiritually-focused psychotherapy for people diagnosed with cancer: A pilot outcome study. *Mental Health, Religion & Culture, 8*(3), 217-226.

Critical Appraisal Skills Programme (CASP): Making sense of evidence. (2013). Retrieved from http://www.casp-uk.net/criticalappraisal

Cummings, J. P., & Pargament, K. I. (2010). Medicine for the spirit: Religious coping in individuals with medical conditions. *Religions, 1*(1), 28-53.

Davis, D., Ashby, J., McElroy, S., & Hook, J. (2014). Religious coping, coping resources, and depressive symptoms: Test of a mediation model. *Counseling and Values, 59*(2), 139-154.

Derogatis, L., & Melisaratos, N. (1983). The brief symptom inventory: An introductory report. *Psychological Medicine, 13*(3), 595-605.

Eliassen, A. (2013). Religious coping and depression in young adulthood: Effects of global stress exposure and pre-teenage religious service attendance. *Review of Religious Research, 55*(3), 413-433.

Faigin, C., Pargament, K., & Abu-Raiya, H. (2014). Spiritual struggles as a possible risk factor for addictive behaviors: An initial empirical investigation. *The International Journal for the Psychology of Religion, 24*(3), 201-214.

*Falb, M., & Pargament, K. (2013). Buddhist coping predicts psychological outcomes among end-of-life caregivers. *Psychology of Religion and Spirituality, 5*(4), 252.

Fard, J., & Bagheri-Nesami, M. (2012). The relationship between general health and religious coping in elderly residing at homes. *Life Science Journal, 9*(4), 3205-3210.

Feder, A., Ahmad, S., Lee, E., Morgan, J., Singh, R., Smith, B. W., ... & Charney, D. (2013). Coping and PTSD symptoms in Pakistani earthquake survivors: Purpose in life, religious coping and social support. *Journal of Affective Disorders, 147*(1), 156-163.

Fernandez, A., & Loukas, A. (2014). Acculturation and religious coping as moderators of the association between discrimination and depressive symptoms among Mexican-American vocational students. *Journal of Immigrant and Minority Health, 16*(6), 1290-1293.

Greenawalt, D., Tsan, J., Kimbrel, N., Meyer, E., Kruse, M., Tharp, D., ... & Morissette, S. (2011). Mental health treatment involvement and religious coping among African American, Hispanic, and white veterans of the wars of Iraq and Afghanistan. *Depression Research and Treatment, 2011,* 1-10. doi:10.1155/2011/192186

Harrison, O., Koenig, H., Hays, J., Eme-Akwari, A., & Pargament, K. (2001). The epidemiology of religious coping: A review of recent literature. *International review of Psychiatry, 13*(2), 86-93.

Hayward, R., & Krause, N. (2015). Evangelical group membership, depression, and well-being among older Mexican Americans: A comparison with older non-Hispanic whites. *Mental Health, Religion & Culture*, *18*(4), 273-285.

Henslee, A., Coffey, S., Schumacher, J., Tracy, M., Norris, F., & Galea, S. (2014). Religious coping and psychological and behavioral adjustment after Hurricane Katrina. T*he Journal of Psychology, 149*(6), 630-642.

Heo, G. (2014). Religious coping, positive aspects of caregiving, and social support among Alzheimer's disease caregivers. *Clinical Gerontologist, 37*(4), 368-385

Heo, G., & Koeske, G. (2013). The role of religious coping and race in Alzheimer's disease caregiving. *Journal of Applied Gerontology, 32*(5), 582-604.

*Herrera, A., Lee, J., Nanyonjo, R., Laufman, L., & Torres-Vigil, I. (2009). Religious coping and caregiver well-being in Mexican-American families. *Aging and Mental Health, 13*(1), 84-91.

Hill, P., & Pargament, K. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58*(1), 64 –74.

Hovey, J., & Seligman, L. (2007). Religious coping, family support, and negative affect in college students. *Psychological Reports, 100*(3), 787-788.

Hsu, H. (2014). Effects of religiousness on depressive symptoms among elderly persons in Taiwan. *Clinical Gerontologist, 37*(5), 446-457.

Katon, W., Lin, E., Von Korff, M., Ciechanowski, P., Ludman, E., Young, B., ... McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *New England Journal of Medicine, 363*(27), 2611-2620.

*Khan, Z., & Watson, P. (2006). Construction of the Pakistani Religious Coping Practices Scale: Correlations with religious coping, religious orientation, and reactions to stress among Muslim university students. *The International Journal for the Psychology of Religion, 16*(2), 101-112.

Koenig, H., King, D., & Carson, V. (2012). *Handbook of religion and health (2nd ed.)*. New York: Oxford University Press.

Koenig, H., Pargament, K., & Nielsen, J. (1998). Religious coping and health status in medically ill hospitalized older adults. *The Journal of Nervous and Mental Disease, 186*(9), 513-521.

Kohn-Wood, L., Hammond, W., Haynes, T., Ferguson, K., & Jackson, B. (2012). Coping styles, depressive symptoms and race during the transition to adulthood. *Mental Health, Religion & Culture, 15*(4), 363-372.

Krumrei, E., Mahoney, A., & Pargament, K. (2011). Spiritual stress and coping model of divorce: A longitudinal study. *Journal of Family Psychology, 25*(6), 973.

*Krumrei, E., Pirutinsky, S., & Rosmarin, D. (2013). Jewish spirituality, depression, and health: An empirical test of a conceptual framework. *International Journal of Behavioral Medicine, 20*(3), 327-336.

Leaman, S., & Gee, C. (2012). Religious coping and risk factors for psychological distress among African torture survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(5), 457.

Levin, J. (2013). Religion and mental health among Israeli Jews: Findings from the SHARE-Israel study. *Social Indicators Research, 113*(3), 769-784.

Lewis, C., Maltby, J., & Day, L. (2005). Religious orientation, religious coping and happiness among UK adults. *Personality and Individual Differences, 38*(5), 1193-1202.

Loewenthal, K., Cinnirella, M., Evdoka, G., & Murphy, P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *British Journal of Medical Psychology, 74*(3), 293-303.

Lonczak, H., Clifasefi, S., Marlatt, G., Blume, A., & Donovan, D. (2006). Religious coping and psychological functioning in a correctional population. *Mental Health, Religion & Culture, 9*(02), 171-192.

McConnell, K., Pargament, K., Ellison, C., & Flannelly, K. (2006). Examining the links between spiritual struggles and symptoms of psychopathology in a national sample. *Journal of Clinical Psychology, 62*(12), 1469-1484.

Nurasikin, M., Khatijah, L. A., Aini, A., Ramli, M., Aida, S., Zainal, N., & Ng, C. (2012). Religiousness, religious coping methods and distress level among psychiatric patients in Malaysia. *International Journal of Social Psychiatry, 59*(4), 332-338.

Olson, M., Trevino, D., Geske, J., & Vanderpool, H. (2012). Religious coping and mental health outcomes: An exploratory study of socioeconomically disadvantaged patients. *Explore: The Journal of Science and Healing, 8*(3), 172-176.

Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions, 2*(1), 51-76.

Pargament, K., Koenig, H., & Perez, L. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology, 56*(4), 519-543.

Pargament, K., Smith, B., Koenig, H., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion, 37*(4), 710-724.

Pearce, M., Singer, J., & Prigerson, H. (2006). Religious coping among caregivers of terminally ill cancer patients: Main effects and psychosocial mediators. *Journal of Health Psychology, 11*(5), 743-759.

*Phillips, R. Michelle-Cheng, C., Oemig, C., Hietbrink, L., & Vonnegut, E. (2012). Validation of a Buddhist coping measure among primarily non-Asian Buddhists in the United States. *Journal for the Scientific Study of Religion, 51*(1), 156-172.

Pirutinsky, S., Rosmarin, D., Pargament, K., & Midlarsky, E. (2011). Does negative religious coping accompany, precede, or follow depression among Orthodox Jews? *Journal of Affective Disorders, 132*(3), 401-405.

Raab, K.. (2007). Manic depression and religious experience: The use of religion in therapy. *Mental Health, Religion & Culture, 10*(5), 473-487.

Radloff, L. (1977). The CES-D scale a self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*(3), 385-401.

Roberts, R., Rhoades, H., & Vernon, S. (1990). Using the CES-D scale to screen for depression and anxiety: Effects of language and ethnic status. *Psychiatric Research, 31*(1), 69–83.

Roemer, M. (2010). Religion and psychological distress in Japan. *Social Forces, 89*(2), 559-583.

*Rosmarin, D., Pargament, K., Krumrei, E., & Flannelly, K. (2009). Religious coping among Jews: Development and initial validation of the JCOPE. *Journal of Clinical Psychology, 65*(7), 670-683.

Sherman, A., Simonton, S., Latif, U., Spohn, R., & Tricot, G. (2005). Religious struggle and religious comfort in response to illness: Health outcomes among stem cell transplant patients. *Journal of Behavioral Medicine, 28*(4), 359-367.

Smith, T., McCullough, M., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129*(4), 614-636.

*Stein, C., Hoffmann, E., Bonar, E., Leith, J., Abraham, K., Hamill, A., ... & Fogo, W. (2013). The United States economic crisis: Young adults' reports of economic pressures, financial and religious coping and psychological well-being. *Journal of Family and Economic Issues, 34*(2), 200-210.

Sternthal, M., Williams, D., Musick, M., & Buck, A. (2010). Depression, anxiety, and religious Life: A search for mediators. *Journal of Health and Social Behavior, 51*(3), 343-359.

Tarakeshwar, N., & Pargament, K. I. (2001). Religious coping in families of children with autism. *Focus on Autism and Other Developmental Disabilities, 16*(4), 247-260.

*Tarakeshwar, N., Pargament, K. I., & Mahoney, A. (2003). Initial development of a measure of religious coping among Hindus. *Journal of Community Psychology, 31*(6), 607-628.

Taylor, R., Chatters, L., & Abelson, J. (2012). Religious involvement and DSM-IV 12 month and lifetime major depressive disorder among African Americans. *The Journal of Nervous and Mental Disease, 200*(10), 856.

Trevino, K., Pargament, K., Cotton, S., Leonard, A., Hahn, J., Caprini-Faigin, C., & Tsevat, J. (2010). Religious coping and physiological, psychological, social, and spiritual outcomes in patients with HIV/AIDS: Cross-sectional and longitudinal findings. *AIDS and Behavior, 14*(2), 379-389.

Winter, U., Hauri, D., Huber, S., Jenewein, J., Schnyder, U., & Kraemer, B. (2009). The psychological outcome of religious coping with stressful life events in a Swiss sample of church attendees. *Psychotherapy and Psychosomatics,78*(4), 240-244.

*Webb, A., Ellison, C., McFarland, M., Lee, J., Morton, K., & Walters, J. (2010). Divorce, religious coping, and depressive symptoms in a conservative protestant religious group. *Family Relations, 59*(5), 544-557.

Yang, W., Zilov, A., Soewondo, P., Bech, O., Sekkal, F., & Home, P. (2010). Observational studies: going beyond the boundaries of randomized controlled trials. *Diabetes Research and Clinical Practice, 88*(1), S3-S9.

* Starred articles indicate those included in the current review

Appendix A

Eight articles did not use Pargament's RCOPE scale or a version/adaptation of it to measure religious coping (Henslee et al., 2014; Leaman & Gee, 2012; Armento, McNulty, & Hopko, 2012; Levin, 2013; Hsu, 2014; Fard & Bagheri-Nesami, 2012; Roemer, 2010; Kohn-Wood, Hammond, Haynes, Ferguson, & Jackson, 2012), one incorporated a large focus on issues of discrimination and acculturation (Fernandez & Loukas, 2014) and four looked more at related religious constructs than religious coping (Hayward & Krause, 2015; Sternthal, Williams, Musick, & Buck, 2010; Braam et al., 2008; Abu Raiya, Pargament, Mahoney, & Stein, 2008). Additionally, four studies focused on only one religious coping method (Heo & Koeske, 2013; McConnell, Pargament, Ellison, & Flannelly, 2006; Pirutinsky, Rosmarin, Pargament, & Midlarsky, 2011; Krumrei, Mahoney, & Pargament, 2011), two included participants with co-morbid psychiatric diagnoses (Nurasikin et al, 2012; Lonczak, Clifasefi, Marlatt, Blume, & Donovan, 2006), one used a measure of depression that was related more to PTSD and earthquake trauma (Feder et al., 2013), one did not measure religious coping (Raab, 2007) and one used a measure for depression which did not appropriately assess the variable (Lewis, Maltby, & Day, 2005). One further study investigated religious coping and religious commitment using measures that assessed largely overlapping areas (Ahles, Mezulis, & Hudson, 2015), two studies did not directly assess the relationship between religious coping and depression (Heo, 2014; Pearce, Singer, & Prigerson, 2006) and five did not measure depression (Kim, Kendall, & Webb, 2015; Greenawalt et al., 2011; Bhui, King, Dein, & O'Connor, 2008; Olson, Trevino, Geske, & Vanderpool, 2012; Aflakseir & Coleman, 2011). Additionally, five articles were unable to be retrieved (Hovey & Seligman, 2007; Winter et al., 2009; Amer, Hovey, Fox, & Rezcallah, 2008; Braam et al., 2014; Buser, Kearney, & Buser, 2015). These were requested but were not received in time for submission of this review.

Appendix B

Data Extraction Forms

Article Author(s)	Aims/Purpose of the Study	Participants	Study Design	Measures Used (Relevant to the review question)	Reliability/ Validity	Results/ Findings	Limitations of the study
1) Braam et al. (2008)	To describe how positive and negative religious coping strategies relate to depressive symptoms, sub-threshold depression and depressive disorder in four ethnic groups.	776 adult respondents of the Amsterdam Health Monitor 2004. 20.8% Moroccans, 24.4% Turkish, 29.4% Surinam/Netherlands Antilles (SNA), 30.2% native Dutch. 211 had no religious affiliation, 151 Christian, 387 Muslim, 9 Hindu, 8 other denominations.	Cross-sectional	1) Symptom Checklist-90 — Revised (SCL-90-R) - Depression subscale 2) Depression section (E) of the Composite International Diagnostic Interview (CIDI) 3) Brief RCOPE.	1) Internal consistency of SCL-90-R depression sub-scale for study sample was high (α=.93). 2) Internal consistency of CIDI depression section not reported. 3) The internal consistency of the positive Brief RCOPE subscale was: Dutch (α = .90), Turkish (α = .86), SNA (α = .89) Moroccans (α = .71). 4) Validity of the positive Brief RCOPE varied, with lower scores for Arabic and Berber than for Dutch and Turkish languages. 5) Reliability and validity of the negative Brief RCOPE subscale was inconsistent for the sample. Therefore, certain items were selected and treated as independent strategies.	1) Positive religious coping was positively associated with depressive symptoms (β=.27) for SNA. 3) For total sample, positive religious coping was only associated with sub-threshold depression (OR = 1.42), not with MDD (OR = 1.27). 4) Punishment reappraisal was most prevalent negative religious coping strategy, especially among Turkish and Moroccan respondents. 5) Four of the five negative coping strategies showed significant associations with depressive symptoms, sub-threshold depression and MDD in the total sample: punishment reappraisal (p=.001; p=.015; p=.009), the abandonment interpretation (p=.000; p=.001; p=.034), questioning the existence of God (p=.008;p=.983;p=.013),	1) Low response rate (net response = 26.5%) and selection criteria (to be considered a particular ethnicity) raises questions regarding the extent of generaliz-ability of the findings. 2) RCOPE was administered in Arabic using translators who were not very fluent, which would lower validity of this measure among

						and expressing anger to God (p=.001; p=.042; p=.482) respectively, where p<.05.	Arabic-speaking participants.
2) Phillips, Michelle-Cheng, Oemig, Hietbrink and Vonnegut (2012)	To create a Buddhist measure of religious coping, and provide evidence of its validity and reliability by correlating it with various measures of adjustment to stress.	The study consisted of 869 Buddhists living in the United States. 45% male, 55% female, average age 46.1 years. 87% Caucasian, 6% Asian, 3% mixed/biracial, 2% Hispanic, 1% mixed/ other races. 13% immigrants who had lived in the US for an average of 18.8 years.	Cross-Sectional	1) BCOPE (Buddhist Coping Measure) 2) Brief Symptom Inventory (BSI) - Depression (six items).	1) Internal consistency of BSI depression sub-scale for study sample was α=.86. 2) Validity for BSI depression sub-scale for study sample not reported, but the study noted a previous article (Derogatis & Meliseratos, 1983) which found high convergence for the BSI subscales with the MMPI subscales, which indicated criterion validity. In this same article, construct and predictive validity were also shown. 3) Internal consistency of BCOPE for study sample was strong (at least α=.71 for 11 of the 14 subscales). 3 subscales (Bad Buddhist, It's Not Easy Being Buddhist, and Mindfulness) had poor internal consistency (α =.57-.66). 4) BCOPE criterion validity was demonstrated through significant correlations with outcome measures. 5) BCOPE construct validity was demonstrated through exploratory and confirmatory factor analyses, which revealed 14	1) BCOPE did correlate with adjustment to stress. With Depression, the correlation was ΔR^2 =0.164 (where p<.001). 2) 4 out of 11 positive coping subscales were significantly, inversely related with depression (Impermanence, Inter-Being, Intentional Morality and Loving-kindness, p<0.001). 3) All 3 negative coping subscales were significantly, positively related to depression (Bad Buddhist, Its not easy being a Buddhist, Fatalistic Karma). 4) Subscales most highly correlated with Depression were: Bad Buddhist (β= +0.269), Fataslistic Karma (β= +0.215) and Impermanence (β= -0.159).	1) Measures were self-report, which could artificially inflate the association between BCOPE and BSI. 2) Participants selected through online measures, so possibility that those who do not use the internet so often were excluded.

					types of Buddhist coping.		
3) Webb et al. (2010)	To examine the impacts of a recent divorce as well as positive and negative religious coping on depressive symptoms.	10,988 Protestant respondents to a biopsycho-social religion and health study conducted 2006-2007. Participants recruited through Protestant churches. 62% White, 33% native-born Black/Caribbean /African, 5% other racial/ethnic minority communities	Cross-sectional	1) Center for Epidemiological Studies of Depression (CES-D) Scale 2) Religious Coping Scale (RCOPE)	1) Internal consistency of CES-D for study sample (α=.81) 2) Validity for CES-D for study sample not reported. 3) Internal consistency of RCOPE for study sample (α=.72 - .88) 4) Validity for RCOPE for study sample not reported. However, authors stated that cases for which more than 3 items were missing, responses were dropped from the analyses. Additionally, study cites a previous article (Pargament, Koenig, & Perez, 2000) showing construct and incremental validity for RCOPE among American participants.	1) Positive religious coping was inversely associated with depressive symptoms, and appeared to mitigate and buffer the deleterious psychological effects of divorce. 2) Negative religious coping was positively related to depression and has a much stronger link than positive religious coping (β = .278, p < .001).	Sample is only representative of 1 denomination, so may not be representative of the broader Christian population.
4) Falb and Pargament (2013)	To investigate the relationship between Buddhist religious coping and psych-ological functioning.	92 end-of-life Buddhist Caregivers. Caucasian (89.1%), female (67.4%), married (62.0%), well-educated (78.3% with post-graduate degrees). They worked predominately with people with cancer.	Cross-sectional	1) Center for Epidem-iological Studies of Depression (CES-D) Scale 2) The Buddhist Coping Scale (BCOPE)	1) CES-D internal consistency for study sample was α=.86 2) Validity of CES-D with study sample not reported, but authors cited a previous article (Radloff, 1977) where CES-D found to discriminate strongly between patient and general population groups, to be sensitive to levels of depressive symptoms, and to correlate well with other depression measures, all of	1) Positive religious coping strategies not significantly related to depression. 2) Negative coping strategies significantly, positively related to depression (β= +0.33, where p<.01). 3) Bad Buddhist coping method was most strongly related to depression (β= +0.33).	1) Highly specific sample size limits general-izability of findings to other populations. 2) Sample consisted of Westerners practicing an Eastern tradition. Thus, current

					which indicated good concurrent, criterion and construct validity. 3) Reliability for RCOPE subscales for study sample was over α=.70 4) BCOPE validity demonstrated through Buddhist coping being related to both positive and negative psychological outcomes for study sample.		results may have been influenced by characteristics of Western Buddhists.
5) Stein et al. (2013)	To investigate religious coping strategies among young adults impacted by the US economic crisis, and to examine the contribution of this coping in accounting for variation in reports of mental health and well-being.	222 young adults from a public Midwestern university. 142 women, 80 men. 85 % Caucasian, 80 % Christian, 20 % no religious beliefs or affiliation, or different affiliation.	Cross-sectional	1) Center for Epidem-iological Studies of Depression (CES-D) Scale 2) Brief RCOPE - three meaning-making subscales of both positive and negative coping methods.	1) CES-D Internal consistency for study sample was α=.93 2) CES-D validity with study sample not reported. However, authors cited a previous article (Roberts, Rhoades, & Vernon, 1990) which demonstrated good validity, among a sample of white Americans and Mexican-Americans. 3) RCOPE subscales internal consistency of study sample was α= .74-.88. 4) RCOPE validity with study sample not reported. However, the study cited a previous article (Pargament Koenig, & Perez, 2000) which found good construct validity among American adults.	1) Religious coping variables were significantly although modestly correlated with scores of depressed mood (ΔR^2=0.03, p<.05). 2) The negative coping method (Punishing God Reappraisals (β = .18)) significantly predicted higher levels of depressed mood. 3) Positive methods were not significantly related to depressed mood.	1) Narrow assessment of religious coping, which may have missed out other forms used. 2) Sample was highly specific, limiting generaliz-bility to other populations.
6) Tarakesh-	To develop a religious	164 Hindus living in the US.	Cross-sectional	1) Center for Epidem-	1) CES-D internal consistency with study	1) Positive religious coping not significantly related to	1) Sample consisted of

war, Pargament and Mahoney (2003)	coping measure for Hindus, and to examine its association with reports of mental health.	59% men, 41% women, 87 married. Participants had lived in the U.S. for average of 11 years		iological Studies of Depression (CES-D) Scale 2) The Hindu Religious Coping Scale - adapted from Pargament's RCOPE.	sample was α=.85 2) CES-D validity with study sample not reported, but authors cited a previous article (Radloff, 1977) which showed good concurrent, criterion and construct validity. 3) Good reliability for Hindu Religious Coping Scale (alphas ranged .69-.85) and discriminant validity (rs .35-.62) among study sample. 4) Predictive validity for the Hindu Religious Coping Scale for study sample was demonstrated through significant correlations with outcome measures. 5) Convergent validity for the Hindu Religious Coping Scale for study sample was supported by significant correlations with some demographic variables and the religious coping subscales.	depression. 2) Negative religious coping significantly, positively associated with higher levels of depression (β= .40, p ≤ .01). 3) Low scores found for some of the "negative religious coping" items including anger at God (M=1.51, SD=.79), feeling punished by God (M=1.52, SD=.87), passive deferral (M=1.31, SD=.63), and high scores for active religious surrender (M=3.06, SD=1.14).	practitioners of an Eastern-based religion, living in a Western country, and may have been influenced by Western social and religious culture. 2) Measures were self-report, which could artificially inflate the association between the Hindu Religious Coping Scale and depression.
7) Rosmarin, Pargament, Krumrei and Flannelly (2009)	To develop a measure of Jewish religious coping (JCOPE) and to investigate it as a predictor of	234 Jewish individuals. 54.7% female, 45.3% male. 99 from Canada, 95 from US, 27 from Israel, 13 from Australia, China,	Cross-sectional	1) Center for Epidem-iological Studies of Depression (CES-D) Scale 2) The Jewish	1) CES-D internal consistency with study sample was α=.93 2) CES-D validity with study sample not reported, but the study cited a previous article (Radloff, 1977) which showed good concurrent, criterion and	1) Positive religious coping significantly, inversely associated with depression (r= -0.19, p<.01), but negative religious coping was significantly, positively associated with depression (r=0.34, p<.01). 2) Positive religious coping	1) Cross-sectional design does not provide information on the direction of influence or causality. 2) Sample

	worry, anxiety, and depression	Portugal, and UK. 60.3% Orthodox, 21.4% Conservative, 5.1% Reform, 13.2% Other.		Religious Coping Scale (JCOPE) - adapted from Pargament's RCOPE.	construct validity. 3) Good incremental validity of JCOPE found in current study, by significantly predicting reduced levels of worry and anxiety, and good concurrent validity, as both subscales of JCOPE were significantly tied to indices of psychological distress. 4) Internal consistencies for the JCOPE positive subscale was α=.92, and the negative subscale was α=.71.	was not a significant predictor of depression, but negative religious coping was a significant predictor of depression (β= 0.32, p<.001).	largely of Orthodox may be more likely to report using religious coping than non-Orthodox, which may have biased the results.
8) Krumrei, Pirutinsky and Rosmarin (2013)	To examine the relationship between religious coping and depressive symptoms	208 Jewish individuals. Modern Orthodox (33 %), Yeshiva Orthodox (22 %), Conservative (15 %), Reform (14 %), Hassidic (2 %), Reconstruction-ist (2 %), Sephardic (2 %), Chabad (1 %), Humanistic (1 %) and other forms of Judaism (8 %). Caucasian (93 %), female (74.5 %), male 25.5%.	Cross-sectional	1) Center for Epidem-iological Studies of Depression (CES-D) Scale 2) The Jewish Religious Coping Scale (JCOPE) - adapted from Pargament's RCOPE.	1) CES-D internal consistency with study sample was α=.89 2) CES-D validity with study sample not reported, but authors cited a previous article (Andresen, Malmgren, Carter, & Patrick, 1994) which reportedly showed good validity among a large sample of older adults. 3) Internal consistencies for JCOPE positive subscale was α=.91, and negative subscale was α=.82. 4) JCOPE validity with study sample not reported, but the study cited a previous article (Rosmarin,	1) Positive religious coping was significantly, inversely related to depressive symptoms (R= 0.26, p<0.01). 2) Negative religious coping was significantly, positively related to depressive symptoms (R= 0.38, p<0.01). 3) Positive religious coping significantly predicted lower levels of depressive symptoms, whereas negative religious coping significantly predicted higher levels of depressive symptoms.	1) Specific sample limits generaliz-ability of findings to other populations. 2) Use of internet-based assessments alone may exclude other factions of Judaism who do not use the internet so frequently.

		83% resided in the U.S., 7% in Canada, 6% in Israel and 4% in other countries.			Pargament, Krumrei, & Flannelly, 2009) which found evidence of good incremental and concurrent validity among an international Jewish sample.		
9) Herrera, Lee, Nanyonjo, Laufman and Torres-Vigil (2009)	To examine religious coping and its association with perceived burden, physical and mental health, and depression.	66 family caregivers of Mexican descent, living in California. 89.4% female, 10.6% male. Roman Catholic (69.7%), Christian (22.7%) and unaffiliated (7.6%).	Cross-sectional	1) Center for Epidem-iological Studies of Depression (CES-D) Scale 2) Short version of the Brief Religious Coping Scale	1) Although the internal consistency of the CES-D and the short version of the Brief RCOPE for the sample used in the study are not reported, the authors do state that all scales administered were validated measures.	1) Positive religious coping was not significantly related to depression 2) Negative religious coping significantly predicted depression (β=0.21, $p<0.05$).	1）High proportion of females in sample, and females known to be more religious and depressed than men. This and self-selection may have biased results. 2）Small sample size limits generaliz-ability to other Mexican-American populations. 3）Using very brief version of RCOPE may have missed out other forms of religious coping 4）Use of translators

							may include minor errors.
10) Bjorck and Thurman (2007)	To investigate the possible moderating effects of positive and negative religious coping on negative life events and psych-ological functioning.	336 Christians. 197 women, 139 men; White (39.3%), African American (28%), Latino/a (13.7%), Asian American (11%), others (8%).	Cross-sectional	1) Center for Epidem-iological Studies of Depression (CES-D) Scale 2) The Brief Religious Coping Scale (Brief RCOPE)	1) CES-D internal consistency for study sample was α=.90 2）CES-D validity for study sample not reported, but authors cited a previous article (Radloff, 1977) showing good concurrent, criterion and construct validity. 3）Internal consistency for the Brief RCOPE positive subscale was α=.83, and negative subscale was α=.79. 4) Brief RCOPE validity with study sample not reported, but authors cited a previous article (Pargament, Smith, Koenig, & Perez, 1998) showing discriminant validity among a young adult American sample.	1) Positive religious coping was not significantly related to depression. 2) After controlling for covariates (questionnaire order and religious participation (services and activities)), positive religious coping was inversely related to depression ($F(1,654)\geq 3.74$, ps ≤ 0.05). 3）Positive religious coping was found to buffer the effects of negative events on functioning. 4）Negative religious coping was significantly related to increased depression ($r = 0.51$, $p < 0.001$). 5）After controlling for covariates (questionnaire order and religious participation (services and activities), negative religious coping was still significantly related positively to depression $F(1,654)\geq 4.32$, ps<0.05). 6) However, negative religious coping did not interact with negative events regarding psychological functioning.	1）Low response rate (27.1%) with no explanation provided. 2) Being asked to recall stressors over the past year may have resulted in errors in recall.
11) Khan	To study the	129 Muslim	Cross-	1) Brief	1) Internal consistency of	1) Pakistani Religious	1）Being

and Watson (2006)	Pakistani Religious Coping Practices Scale and the Brief RCOPE in Pakistan, and to examine their correlations with depressed, anxious and hostile reactions to stress.	students at the University of Karachi. 68 female, 61 male.	sectional	Symptom Inventory (BSI) - Depression (six items). 2) The Pakistani Religious Coping Practices Scale 3) The Brief Religious Coping Scale (Brief RCOPE)	Depression subscale of BSI for study sample was α=.78 2）Validity of Depression subscale of BSI for study sample not reported. 3）Internal consistency for the Brief RCOPE positive subscale was α=.75, and negative subscale was α=.60. 4）Internal consistency of Pakistani Religious Coping Practices Scale for study sample was α=.74. 5）Parallel results with Western findings provided support for validity of Brief RCOPE among Pakistani Muslims. 6) The study also found that both Pakistani Religious Coping Practices Scale and Brief RCOPE were related to outcome measures, although this was weak for the former measure.	Coping Scale was not significantly correlated to depression. 2) However, partial, negative correlations were found between Depression and the Pakistani Religious Coping Practices Scale (–.15, $p < .05$) after the variance associated with Negative Religious Coping was removed. This correlation was weak. 3) RCOPE Negative Religious Coping subscale was significantly, positively correlated with depression (r=0.43, $p < .01$). 4) RCOPE Positive Religious Coping subscale was not significantly correlated to depression. 5) However, partial, negative correlations were found between Depression and Positive Religious Coping (–.24, $p < .01$) after the variance associated with Negative Religious Coping was removed. This correlation was weak.	asked to recall a major stressor in life may have introduced sources of errors in recall, and too large a variety of stressors. 2）Does not clarify the sect of Muslims, which would have implications for the kind of religious coping methods used. 3) Sample belonged to elite social classes, and were likely to have more Western influence than non-university students.

Appendix C

CASP Quality Appraisal of Articles

Article Author(s)	Address clearly focused issue?	Acceptable recruitment?	Exposure measured to minimize bias?	Outcome accurately measured to minimize bias?	Confounding factors identified?	Confounding factors considered in design analysis?	Follow-up of subjects complete and long enough?
1) Braam et al. (2008)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
2) Phillips, Michelle-Cheng, Oemig, Hietbrink and Vonnegut (2012)	Yes	Yes	Yes	Yes	No	Yes	N/A
3) Webb et al. (2010)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
4) Falb and Pargament (2013)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
5) Stein et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
6) Tarakeshwar, Pargament, and Mahoney (2003)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
7) Rosmarin, Pargament, Krumrei, E., and Flannelly, (2009)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
8) Krumrei, Pirutinsky and Rosmarin (2013)	Yes	Yes	Yes	Yes	Yes	Yes	N/A

9) Herrera, Lee, Nanyonjo, Laufman and Torres-Vigil (2009)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
10) Bjorck, and Thurman(2007)	Yes	Yes	Yes	Yes	Yes	Yes	N/A
11) Khan and Watson (2006)	Yes	Yes	Yes	Yes	No	Yes	N/A

CASP Quality Appraisal of Articles (continued)

Article Author(s)	What are the results?	Confidence intervals reported?	Researcher believes results?	Can results be applied to the broader population of the sample?	Results fit with available evidence?	Study implications for practice
1) Braam et al. (2008)	1) Positive religious coping was positively associated with depressive symptoms(β=.27) for SNA. 3) For total sample, positive religious coping was only associated with sub-threshold depression (OR = 1.42), not with MDD (OR = 1.27). 4) Punishment reappraisal was most prevalent negative religious coping strategy, especially among Turkish and Moroccan respondents. 5) Four of the five negative coping strategies showed significant associations with depressive symptoms,	Yes	Yes	No - low response rate and criteria for selection limits applicability to broader ethnic population.	Yes & No. No: Previous research largely shows that positive religious coping is negatively related to depression, which was inconsistent with some findings of the study. Yes: Previous research largely shows	The frank response of Muslim participants reveals that it is by and large feasible to discuss the positive aspects of religiousness and religious distress with Muslims, especially among Turkish Muslims.

	sub-threshold depression and MDD in the total sample: punishment reappraisal (p=.001; p=.015; p=.009), the abandonment interpretation (p=.000; p=.001; p=.034), questioning the existence of God (p=.008;p=.983;p=.013), and expressing anger to God (p=.001; p=.042; p=.482) respectively, where p<.05.				that negative religious coping is positively related to depression which was consistent with the findings of the current study.	
2) Phillips, Michelle-Cheng, Oemig, Hietbrink and Vonnegut (2012)	1) BCOPE did correlate with adjustment to stress. With Depression, the correlation was ΔR^2=0.164 (where p<.001). 2) 4 out of 11 positive coping subscales were significantly, inversely related with depression (Impermanence, Inter-Being, Intentional Morality and Loving-kindness, p<0.001). 3) All 3 negative coping subscales were significantly, positively related to depression (Bad Buddhist, Its not easy being a Buddhist, Fatalistic Karma). 4) Subscales most highly correlated with Depression were: Bad Buddhist (β= +0.269), Fataslistic Karma (β= +0.215) and Impermanence (β= -0.159).	No	Yes	Yes	Yes	BCOPE can be used to assess Buddhist resources and struggles within therapy sessions, monasteries, or sanghas, or to evaluate psycho-spiritual interventions that include Buddhist ideas and practices.
3) Webb et al. (2010)	1) Positive religious coping was inversely associated with depressive symptoms, and	No	Yes	Yes	Yes	Family counselors and others should bear in mind that religious and spiritual resources can provide

	appeared to mitigate and buffer the deleterious psychological effects of divorce. 2) Negative religious coping was positively related to depression and has a much stronger link than positive religious coping ($\beta = .278$, $p < .001$).					important help for individuals dealing with divorce and its aftermath. Second, that specific religious coping approaches may be related to both salutary and undesirable psychosocial variables. Further, religious counselors could help recently divorced individuals draw on scriptural and community resources, including prayer as well as other devotional practices in order to help their adjustment to divorce while also helping to avoid potentially harmful religious coping styles.
4) Falb and Pargament (2013)	1) Positive religious coping strategies not significantly related to depression. 2) Negative coping strategies significantly, positively related to depression ($\beta = +0.33$, where $p<.01$). 3) Bad Buddhist coping method was most strongly related to depression ($\beta = +0.33$).	No	Yes	No - sample largely (89%) consisted of Caucasian individuals.	Yes & No No: Previous research largely shows that positive religious coping is negatively related to depression, which was inconsistent with the findings of the study. Yes: Previous research largely shows that negative religious coping is positively related to	The findings of psychology of religion are applicable to Buddhist coping.

					depression which was consistent with the findings of the current study.	
5) Stein et al. (2013)	1) Religious coping variables were significantly but modestly correlated with depressed mood scores (ΔR^2=0.03, p<.05). 2) The negative coping method (Punishing God Reappraisals (β = .18)) significantly predicted higher levels of depressed mood. 3) Positive methods were not significantly related to depressed mood.	No	Yes	Yes	Yes & No. No: Previous research largely shows that positive religious coping is negatively related to depression, which was inconsistent with the findings of the study. Yes: Previous research largely shows that negative religious coping is positively related to depression which was consistent with the findings of the current study.	Findings can assist intervention programs that are designed to help college students to cope with financial pressures.
6)	1) Positive religious coping not	No	Yes	Yes	Yes & No.	The use of religious resources

Tarakeshwar, Pargament and Mahoney (2003)	significantly related to depression. 2) Negative religious coping significantly, positively associated with higher levels of depression (β= .40, $p \leq .01$). 3) Low scores found for some of the "negative religious coping" items including anger at God (M=1.51, SD=.79), feeling punished by God (M=1.52, SD=.87), passive deferral (M=1.31, SD=.63), and high scores for active religious surrender (M=3.06, SD=1.14).				No: Previous research largely shows that positive religious coping is negatively related to depression, which was inconsistent with the findings of the study. Yes: Previous research largely shows that negative religious coping is positively related to depression which was consistent with the findings of the current study.	should be considered when dealing with Hindu clients, using an approach that is sensitive to Hindu theological principles, such as the Hindu Religious Coping Scale from the current study. Further, clinicians need to be mindful of and sensitive to the religious struggles of Hindus, which appear to be related to greater distress.
7) Rosmarin, Pargament, Krumrei and Flannelly (2009)	1) Positive religious coping significantly, inversely associated with depression (r= -0.19, p<.01), but negative religious coping was significantly, positively associated with depression (r=0.34, p<.01). 2) Positive religious coping	No	Yes	Yes	Yes	JCOPE can be a useful assessment tool for religious coping for clinicians working within the Jewish community

	was not a significant predictor of depression, but negative religious coping was a significant predictor of depression (β= 0.32, p<.001).					
8) Krumrei, Pirutinsky and Rosmarin (2013)	1) Positive religious coping was significantly, inversely related to depressive symptoms (R= 0.26, p<0.01). 2) Negative religious coping was significantly, positively related to depressive symptoms (R= 0.38, p<0.01). 3) Positive religious coping significantly predicted lower levels of depressive symptoms, whereas negative religious coping significantly predicted higher levels of depressive symptoms.	Yes	Yes	Yes	Yes	Adds knowledge of how religion and spirituality might be relevant to the Jewish community and mental health among this community.
9) Herrera, Lee, Nanyonjo, Laufman and Torres-Vigil (2009)	1) Positive religious coping was not significantly related to depression 2) Negative religious coping significantly predicted depression (β=0.21, p<0.05).	No	Yes	Yes	Yes & No. No: Previous research largely shows that positive religious coping is negatively related to depression, which was inconsistent with the findings of the study. Yes: Previous research largely shows	Primary care providers can help caregivers connect with the beneficial aspects of their existing belief system or facilitate interactions with the appropriate religious individuals or leadership so as to extend help and provide necessary services to caregivers who are stressed.

					that negative religious coping is positively related to depression which was consistent with the findings of the current study.	
10) Bjorck, and Thurman (2007)	1) Positive religious coping was not significantly related to depression. 2) After controlling for covariates (questionnaire order and religious participation (services and activities)), Positive religious coping was inversely related to depression ($F(1,654) \geq 3.74$, ps ≤ 0.05). 3) Positive religious coping was found to buffer the effects of negative events on functioning. 4) Negative religious coping was significantly related to increased depression ($r = 0.51$, $p < 0.001$). 5) After controlling for covariates (Questionnaire order and religious participation (services and activities), negative religious coping was still significantly related positively to depression $F(1,654) \geq 4.32$, ps<0.05).	No	Yes	Yes	Yes	Positive patterns of religious coping can be useful in helping to buffer the effects of negative life events. Therefore, understanding the important distinction between positive and negative religious coping will be valuable to researchers studying the psychology of religion, as well to community psychologists, pastoral counselors, and other clinicians working with religious clients.

	6) However, negative religious coping did not interact with negative events regarding psychological functioning.					
11) Khan and Watson (2006)	1) Pakistani Religious Coping Scale was not significantly correlated to depression. 2) However, partial, negative correlations were found between Depression and the Pakistani Religious Coping Practices Scale (–.15, $p < .05$) after the variance associated with Negative Religious Coping was removed. This correlation was weak. 3) RCOPE Negative Religious Coping subscale was significantly, positively correlated with depression ($r=0.43$, $p < .01$). 4) RCOPE Positive Religious Coping subscale was not significantly correlated to depression. 5) However, partial, negative correlations were found between Depression and Positive Religious Coping (–.24, $p < .01$) after the variance associated with Negative Religious Coping was removed. This correlation was weak.	No	Yes	No - as sample belonged to elite social class which was not representative of the larger Pakistani population.	Yes & No. No: Previous research largely shows that positive religious coping is negatively related to depression, which was inconsistent with some findings of the study. Yes: Previous research largely shows that negative religious coping is positively related to depression which was consistent with the findings of the current study.	The Brief RCOPE would be useful in planned future studies of Pakistani samples.

Part B: Research Report

Religious Coping and Depressive Symptoms: A Study of the Ismaili Community in Kenya

Abstract

In the last few years, researchers have become aware of significant links between religion and mental health (Copeland-Linder, 2006; Harris et al., 2012; Wei & Liu, 2013). One area in particular that has received increased attention among psychological researchers is religious coping and its relationship with depressive symptoms. Although research in this field has largely reported that religious coping is related to lower depression levels, a major limitation is that these studies focus significantly on populations living in Western countries and belonging to the Christian faith. The current study therefore examined religious coping and depressive symptoms in the context of the Ismaili religious community in Nairobi, Kenya. Specifically, it explored how Ismaili adults understood their experience of depressive symptoms in terms of their religion, and how they used aspects of their religion to cope with the depressive symptoms. Qualitative research was selected as the research method for the study. Six participants were interviewed using semi-structured interviews and the data was analyzed using Interpretive Phenomenological Analysis (IPA). Four super-ordinate themes and twelve sub-ordinate themes emerged which were prominent across the six interviews. Overall, the findings indicated that religion appears to have both positive and negative influences on depressive symptoms, a finding that is generally supported the wider literature on religious coping and is mostly congruent with Pargament's (1997) research. Clinical implications for practice, limitations and areas for future research are discussed in relation to these findings.

1. Introduction

For thousands of years, religious faiths have taught and advised specific methods drawn from the practice of religion to better handle major life struggles. In spite of the close connections between religion and coping, it is only in the last decade that this relationship has begun to receive greater attention from researchers in the mainstream of modern psychological inquiry. More recently, religion and its implications for mental health and well-being have received particular interest the field of psychology (Pargament & Raiya, 2007). These areas have been widely investigated (Abdel-Khalek & Lester, 2007; Cinnirella & Loewenthal, 1999; Copeland-Linder, 2006; Harris et al., 2012; Hussain & Cochrane, 2003; Loewenthal, MacLeod, Goldblatt, Lubitsh & Valentine, 2000; Pargament, 1997; Schettino et al., 2011; Stanley et al., 2011; Wei & Liu, 2013).

1.1 Religious Coping

According to Koenig, King, and Carson (2012), religion constitutes a set of practices, beliefs, and associated rituals that are related to the sacred. It may involve beliefs about spirits, both good and bad, it may be organized and practiced within a community, or it may be practiced in private. There are several dimensions of religion including religious affiliation, religiosity, organizational and non-organizational religiousness, religious involvement, religious participation and religious coping. Although many of these dimensions have been variously defined by different researchers (Hill & Pargament, 2003; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; McFadden, 1995; Stolzenberg, Blair-Loy, & Waite, 1995), one of these dimensions, religious coping, was originally defined and researched intensely by a single author, Kenneth Pargament. Over the last two decades, religious coping and its impact on health and well-being has received significant attention in the research field (Pargament, 1997), and Pargament's definition of religious coping is not only the most widely used in research today (Aflakseir & Coleman, 2011), but it is also largely applicable to different religions (Abu Raiya, Pargament, Mahoney, & Stein, 2008). Pargament's definition of religious coping will therefore be used as the conceptual foundation for understanding religious coping in the current study.

Pargament (1997) defined religion as "a search for significance in ways related to the sacred" (p.32), and defined 'coping' as "a search for significance in times of stress" (p.90).

Religious coping was therefore defined as "the use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Koenig, Pargament, & Nielsen, 1998, p.513). In his research, Pargament believed that religion served a variety of functions in day-to-day living and in crisis, and he identified five particular functions of religion to this effect (Pargament, Koenig, & Perez, 2000). These were search for meaning, gaining control, providing comfort from apprehension and desiring to connect with a greater force, gaining intimacy with others and a higher power through spiritual methods, and making major life transformations. Religious coping methods were therefore conceptualized with respect to each of these five functions. What he recognized, however, was that religious coping has two faces to it, one that reflected a positive relationship with God, and one that reflected a negative relationship, both of which had differing impacts on well-being (Pargament et al., 2000).

Pargament defined positive religious coping as attempts to maintain a loving and supportive relationship with God, and to use religious beliefs to re-frame or reduce the importance of personal difficulties. This positive religious foundation would then be manifest in religious coping behaviors such as "benevolent religious reappraisals, collaborative religious coping, seeking spiritual support, religious purification, seeking help from clergy or members, religious helping, and religious forgiveness" (Pargament, Smith, Koenig, & Perez, 1998, p.712). Benevolent religious reappraisals involves interpreting the stressor through religion as being beneficial and benevolent, collaborative religious coping involves solving the stressor by developing a partnership with God, and religious purification involves performing religious actions to attain religious cleansing in hope of resolving the stressor. He defined negative religious coping as involving beliefs of an ominous view of the world, expressing a tenuous relationship with God and a struggle to find meaning (Bjorck & Thurman, 2007). This negative religious foundation would then be manifest in religious coping behaviors such as "punitive religious reappraisals, demonic religious reappraisals, reappraisals of God's powers, and interpersonal religious discontent" (Pargament et al., 1998, p.712). Punitive religious reappraisals involve viewing the stressor as a punishment from God, demonic religious reappraisals involve viewing the stressor as an act of the devil, reappraisals of God's powers is questioning God's powers to solve the

stressor, and interpersonal religious discontent involves experiencing dissatisfaction with the religious community in relation to the stressful situation.

Based on these definitions, Pargament expanded his research to include both positive and negative religious coping methods. A simple way of differentiating these two ways of religious coping methods is to identify ways of turning to religion as 'positive religious coping,' such as, seeking forgiveness and asking for God's love and care, and ways of turning away from religion as 'negative religious coping,' such as, feeling punished by God and feeling anger at God (Tarakeshwar, Pargament, & Mahoney, 2003). These methods later constituted the Religious Coping Questionnaire (RCOPE), a comprehensive measure of 21 different types of religious coping methods that reflect how an individual makes use of religion to understand and deal with stressors. The RCOPE is currently the most widely used measure for religious coping, and numerous studies have established its reliability and validity (Khan & Watson, 2006; Pargament et al., 2000; Pargament, Feuille, & Burdzy, 2011; Tarakeshwar & Pargament, 2001).

Although Pargament's research on religious coping primarily focused on religion, certain aspects also included spirituality. Importantly, Pargament noted that religion and spirituality represented related constructs rather than independent ones (Hill & Pargament, 2003). He defined spirituality as a search for the sacred, which takes place in a larger religious context. This search is a process through which people seek to explore and discover the divinity within that which they hold sacred in their lives. He described the sacred as representing a transcendent power that guides individuals in constructive ways and includes concepts such as God, the divine, ultimate reality, as well as any other aspect of life that takes on extraordinary nature due to its relation with such concepts (Faigin, Pargament, & Abu-Raiya, 2014). Working with this conceptualization, Pargament realized that religious coping methods which demonstrate attempts to gain closeness with God may also reflect a spiritual function of searching for the sacred. Pargament therefore developed additional methods to this effect and included them in the RCOPE (Hill & Pargament, 2003).

While some researchers have concurred with this Pargament's conceptualization of a related, rather than independent, relationship between the two constructs (Highfield, 2001; Koenig, 2009; Koenig, McCullough, & Larson, 2001), others have shown differences. For

instance, Oman (2014) notes that religion connotes the organized and institutionalized components of faith traditions, whereas spirituality refers to the more inward and personal aspects. Doyle (1992) also noted that while religion is a defined as a set of practices that are undertaken by those who profess a particular faith, spirituality involves a search for existential meaning. However, in response to this, Hill and Pargament (2003) have warned that polarization of religion and spirituality potentially ignores the fact that, according to the authors, spirituality is often experienced within an organized religious context. Regarding self-definition, other research indicates that some individuals identify themselves as 'spiritual but not religious,' and tend to reject traditional organized religion in favor of an individualized spirituality. However, little is known about this group and further research is still needed to understand how religion and spirituality are understood among this population (Oman, 2014). Thus, despite the surge of research interest in both religion and spirituality, the diversity in the definitions of religion and spirituality suggests the lack of a comprehensive and overall consensus on what each construct means. Nevertheless, Pargament's conceptualization of the two constructs are noted to be among the most influential approaches (Oman, 2014) and will be used in the current study. Furthermore, his conceptualization has been absorbed in measures of religious coping for other religions such as Judaism (Rosmarin, Pargament, Krumrei, & Flannelly, 2009), Hinduism (Tarakeshwar, Pargament, & Mahoney, 2003) Buddhism (Phillips, Michelle-Cheng, Oemig, Hietbrink, & Vonnegut, 2012), and Islam (Aflakseir & Coleman, 2011).

1.1.1 Depression.

According to a 2016 report published by the World Health Organization (WHO), depression is the leading cause of disability worldwide for both men and women and was noted to contribute significantly to the global burden of disease (WHO, 2016). Further that on average, 1 in 20 people reported having an episode of depression in 2011 across 17 different countries (Marcus, Yasamy, van Ommeren, Chisholm, & Saxena, 2012). These figures clearly indicate the pervasiveness and steady rise of depression around the world.

Clinical depression is currently defined using the Diagnostic and Statistical Manual of Mental Disorders criteria. According to this criteria, some symptoms include depressed mood, diminished interest or pleasure, significant weight loss or gain, insomnia or

hypersomnia and feelings of worthlessness or excessive guilt (5th ed.; DSM–5; American Psychiatric Association, 2013). However, it is important to note that depressive symptoms may be understood and experienced differently among various cultures, and cross-cultural validity is an important consideration when measuring depression among varied populations.

1.2 Religious Coping and Depressive Symptoms

In cross-sectional and longitudinal studies, the use of religious coping has been associated with a variety of indicators of mental health (i.e., depression, positive affect, life satisfaction). Furthermore, the relationship between religious coping and mental health remains significant after controlling for the effects of socio-demographic variables and global religious measures (e.g., frequency of prayer and church attendance) (Koenig, Cohen, Blazer, Kudler, Krishnan, & Sibert, 1995; Pargament, 1997; Park & Cohen, 1993). However, studies that specifically examine the relationship between religious coping and depressive symptoms, are fewer and the findings tend to be mixed.

For example, Taylor, Chatters and Abelson (2012) explored relationships between lifetime and 12-month DSM-IV Major Depressive Disorder (MDD) and religious involvement among African American adults and found that positive forms of religious coping were inversely associated with 12-month MDD. In another study, Eliassen (2013) examined how attendance at religious services during formative years might influence the development of an association between religious coping and depressive symptoms, and how this process would vary by level of global stress exposure. The results indicated a significant negative relationship between religious coping and depressive symptoms for young women with above-average stress exposure. However, some studies have shown no relationship between religious coping and depressive symptoms (e.g., Ai, Huang, Bjork, & Appel, 2013; Kohn-Wood, Hammond, Haynes, Ferguson, & Jackson, 2012).

Other studies have suggested that the relationship between religious coping and depressive symptoms is determined by the religious coping method used. However, these findings also tend to be mixed. For example, one finding is that the use of positive religious coping methods is associated with lower levels of depression, while the use of negative religious coping methods is associated with higher levels of depression (Cole, 2005; Davis, Ashby, McElroy, & Hook, 2014; Pargament & Raiya, 2007). Other studies indicate that

only negative religious coping impacts levels of depression, while positive religious coping is unrelated to depression (Krumrei, Mahoney, & Pargament, 2011; Leaman & Gee 2012; Sherman, Simonton, Latif, Spohn, & Tricot, 2005; Trevino et al., 2010). Additionally, one longitudinal study found that negative religious coping precedes and even causes depressive symptoms (Pirutinsky, Rosmarin, Pargament, & Midlarsky, 2011).

What appears to underlie these different findings is the way religious coping is measured. Specifically, it seems that studies which measured both positive and negative religious coping using scales appeared to largely report findings that fit within and reflected that dichotomy. This means that, in these studies, religious coping was largely reported to have a positive and/or negative relationship with depression. However, studies that measured religious coping using interview questions, such as one's frequency of prayer or orientation to God during stress, largely reported findings that reflected only those particular aspect of religious coping. As a result of these differences, the findings across both kinds of studies were mixed. In addition, both kinds of studies differed in the specific measures used. For example, both Davis et al. (2014) and Leaman and Gee (2012) used scales to measure religious coping, however the former used the Religious Coping Scale–Brief Version (Pargament et al., 1998) and the latter used the Brief Multidimensional Measure of Religiousness and Spirituality (BMMRS; Idler et al., 2003). Additionally, Eliassen (2013) measured religious coping by asking participants three questions regarding turning to religion, seeking comfort from religion and praying during times of stress, where as Ai et al. (2013) measured the construct by asking participants only one question regarding the frequency of turning to religion during stress. Thus, while this highlights the variations of measurement methods of religious coping currently used in research, the lack of a consistent method or tool of measurement significantly limits the ability to draw conclusions regarding what exactly religious coping constitutes and its overall influence on depressive symptomology.

Regarding meta-analyses, none, to the researcher's knowledge, were found to specifically examine religious coping and depressive symptoms. However, six were found to include a focus on religious coping and depressive symptoms and all reported their findings in terms of positive and negative religious coping. For instance, the earliest meta-analysis observed that the lowest rates of depressive symptoms were associated with

positive religious coping, and that increased depressive symptoms were associated with negative religious coping (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001). Smith, McCullough and Poll (2003) also noted that while negative religious coping was strongly related to greater depressive symptoms, positive religious coping was only mildly related to reduced depressive symptoms. Ano and Vasconcelles (2005) reviewed 49 studies examining religious coping and adjustment to stress and found that positive religious coping was related to positive adjustment, which included lower rates of depression, and inversely related to negative adjustment, which included higher rates of depression. Additionally, that negative religious coping was unrelated to positive adjustment, but positively related to negative adjustment.

More recently, Pargament and Raiya (2007) published a review of studies that investigated the relationship between religious coping and mental health. They found that positive religious coping was positively and persistently associated with desirable mental health indicators such as reduced anxiety, depression, and increased optimism and relationships with others. Conversely, negative religious coping was associated with poorer mental health outcomes such as decreased feelings of hope, increased post-traumatic stress symptoms, anger and distress. Another review also noted that positive religious coping was linked to lower depression and negative religious coping was linked with higher depression (Abu-Raiya & Pargament, 2015). In the most recent review, Cummings and Pargament (2010) also found similar results among patients with various medical conditions such as heart failure, cancer, diabetes, and HIV/AIDS. The results of these meta-analyses indicate that negative and positive methods of religious coping seem to be related to higher and lower rates of depressive symptoms, respectively.

1.3 Religious Coping and Islam

Most of the studies examining religious coping have been carried out among Judeo-Christian populations, and limited research exists among non-Judeo-Christian populations, such as Muslims. Islamic literature gives certain recommendations related to coping with difficulties such as praying to God, fasting, making holy pilgrimages, and reciting certain verses from the Quran. The remembrance of God is also encouraged. For example, the Quran says: “Those who believe, and whose hearts find their rest in the remembrance of God -- for, verily, in the remembrance of God [men's] hearts do find their

rest" (13:12). The Quran further gives individuals meaningful interpretations of difficult events, by emphasizing that difficulties exist to test the individual. Therefore, followers are advised to be patient when dealing with their problems (Aflakseir & Coleman, 2011).

Although few studies on religious coping have been conducted with Muslim participants, recent years have witnessed a steady increase (eg. Ai, Peterson, & Huang, 2003; Cinnirella & Loewenthal, 1999; Khan, Watson, & Chen, 2011; Khawaja, 2008; Rodriguez, Khan, & Selya, 2012; Sahraian, Gholami, Javadpour, & Omidvar, 2013). Although the results indicate that further research is needed to draw firmer conclusions on the prevalence and implications of religious coping among Muslim populations, the overall pattern of the findings seem to indicate that Muslim individuals do turn to religion during times of stress and that different forms of religious coping have different relationships with health and well-being.

For instance, Bhui, King, Dein and O'Connor (2008) compared patterns of religious coping across six ethnic groups which consisted of participants belonging to six different religions including Christian, Muslim, Sikh, Hindu, Buddhist, and Rastafarian. The study revealed that Muslims were one of two groups that most often found that religious rituals and formal religious practices were most important to their coping. Specifically, the study noted that embracing distress, becoming more adherent to religious practices, listening to religious words, offering service to people, praying, and reciting religious verses were most often used by the Muslim participants to cope with distress. Aflakseir and Coleman (2011) also studied the relationship between religious coping and Iranian veteran mental health and found that religious coping significantly impacted general mental health and PTSD. Specifically, they found that participants used positive religious coping more frequently than negative religious coping.

1.3.1 Religious coping and depressive symptoms among Muslim populations.

A limited number of studies have explored specifically how depression is understood among Muslims, as well as coping strategies used to manage the symptoms experienced among this population. The research generally indicates that among many Muslims, the perceived causes and cures of depression are strongly related to religion (Cinnirella, & Loewenthal, 1999; Hodge, 2005; Skinner, 2010; Walpole, McMillan, House, Cottrell, & Mir, 2012). The research also shows that Muslims do turn to their religion during an

experience of depression. For instance, among a sample of Christians, Muslims, Hindus and Jews, Cinnirella and Loewenthal (1999) found that prayer was perceived as the most effective strategy to cope with depressive and schizophrenic symptoms among Muslim participants. Hussain and Cochrane (2003), in a study on Muslim women with depression, also found that coping through religion was the most common strategy, where the women prayed for help and many read verses from the Quran specifically to ask for protection from illnesses. This coping strategy reportedly helped to ease the burden of the depressive symptoms they were experiencing.

Additionally, Abdel-Khalek and Eid (2011) investigated the association between religion and depression among Kuwaiti and Palestinian Muslim children and adolescents. The researchers found significant negative correlations between religion and depression. Other studies have explored Arab Muslim populations in Saudi Arabia and Algeria, and reported a positive relationship between the practice of religion and well-being, including happiness and mental health, and a negative relationship between religion and psychopathology, such as neuroticism, anxiety and depression (Abdel-Khalek & Lester, 2007; Abdel-Khalek & Naceur, 2007).

Not all studies have shown that religious coping is helpful in dealing with depressive symptoms among Muslim individuals. For example, Feder et al. (2013) found no relationship between positive religious coping and depressive symptoms among 200 Pakistani survivors of the 2005 Pakistan earthquake. Other studies show similar findings (Amer, Hovey, Fox, & Rezcallah, 2008; Khan & Watson, 2006). Although these studies help provide an overview of the research conducted in this field, they indicate that it is still an under-researched area which needs further literature to better clarify aspects of the relationship between religious coping and depressive symptoms, especially among Muslim populations.

1.3.2 The Ismaili religious community.

It has often been stated that the Ismaili religious community is a "tiny minority of a minority within the larger Muslim faith" (Daftry, 1998, p. 5). According to Kassam (1995), Ismailis are estimated to comprise approximately eight percent of the narrower Shia sect of Islam, itself comprising only a fifth of the entire Muslim world. It is not surprising, therefore, that Ismailis have remained largely unknown to the rest of the world for much of

their existence. Due to the rapid increase in globalization over the last century, however, members of the community have spread out over 25 countries. They are an ethnically and culturally diverse community, but united over their common allegiance to the Ismaili spiritual leader, His Highness The Aga Khan IV (see Appendix A for a brief history of His Highness The Aga Khan IV and an explanation of his role as the Ismaili spiritual leader). Particularly large numbers currently reside in India, Pakistan, United States of America, East Africa and Canada (Kassam, 1995) (see Appendix B for a brief history of the Ismaili religion and an explanation of relevant, religious terms).

Research on the Ismaili community has been extremely sparse. Studies conducted among Ismailis in East Africa began in the early 1950's. These studies focused on the progress of the community in East Africa (Morris, 1956), their adjustment to colonized East-African nations (Adams, 1979; Bocock, 1971), and didactic accounts of the faith (Anderson, 1964; Clarke, 1976). During the Ugandan expulsion of Asians in the late 1970's thousands of Ismailis had to flee their homes in Uganda as well as in Kenya and Tanzania, with many moving to the United Kingdom and Canada. The result of this mass migration led to a new direction in the research on Ismailis. Approximately 15 years after the migration, empirical studies began investigating the long-term psychological effects of migration, changes in ethnic identity as a result of migration, and empowerment among the elderly (Dossa, 1994; Dossa 1999; Emadi, 2005). In the last 15 years, there appeared to be a growth in the study of Ismailis and researchers began exploring more contemporary issues within the community such as education for women (Keshavjee, 2010), gender roles (Damji & Lee, 1995), and identity (Virani, 2011) and mental health in relation to immigrant adaptation (Khuwaja et al., 2007).

1.3.2.1 Depression in the Ismaili community in Nairobi.

Unfortunately, there are no empirical research studies available on how depression is understood or defined within the Ismaili community. Literature on other Muslim communities suggests that members of these communities tend to believe that the perceived causes and cures of depression are strongly related to religion and that they do turn to their religion during an experience of depression (Walpole et al., 2012). However, to the researcher's knowledge, current literature has not confirmed these findings among the

Ismaili religious community. In the current study, depression was not specifically defined but was left open as a subjective experience in the context of people's lives.

Regarding the rates of depression among Ismaili Muslims in Kenya, the only figures available for Nairobi Ismailis are compiled by the Ismaili Community Counselling Services (CCS), which comprise of accumulated statistics of clients with depression and other problems, who have accessed the service. According to these statistics, the figures over the last 5 years (2011 through 2015) indicate that the percentage of adults experiencing depression increased by 945% (Community Counselling Services, 2015). It is possible that this figure may be an overestimation of the actual percentage of adult Ismailis with depression, as not all individuals may have undergone a formal diagnostic process. It is further possible that the figure may be an underestimation as the data would not include Ismailis with depression who did not access the service. Nevertheless, given the figure available and the stark rise it indicates among such a minority community in Nairobi, it is quickly becoming important to carry investigations on the possible treatments for this problem.

Although there are no known empirical studies on depressive symptoms among adult Ismailis in Kenya, one study did investigate this area of research among Ismaili adolescents in the United States (Khuwaja et al., 2007). This study examined post-migration depression among Pakistani Ismaili adolescent females and found that factors including longer stays in the United States, being at a young age at the time of migration and greater fluency in English, were all related to a lower likelihood of depression. Although these results highlight important factors that may help mitigate the levels of depression among Ismaili adolescents in the United States, the context, sample population and research question, to a large extent, differ from those of the current study and therefore generalizing the results to adults in a Kenyan context is limited.

From the existing literature on religious coping and depressive symptoms, it is clear that not only has this area gradually become one of interest among the research community, but more recently, it has diversified to include non-Western populations. Furthermore, and as noted earlier, research specifically on Muslim populations has become more available. However, research on minority religious communities within Islam, such as the Ismaili religious community, is extremely sparse and only one study, to the researcher's knowledge,

has investigated depression. No known study has investigated how religion influences the way Ismaili adults cope with their experiences of depressive symptoms. The benefits of this investigation include an important contribution of scholarly research on the Ismaili community, insights about depressive symptoms as understood and experienced by this minority community, and an opportunity to inform and improve clinical practice when working therapeutically with clients experiencing depressive symptoms in the Ismaili-Kenyan context.

2. Context for the Present Research Study

According to Srivastava (2013), there are approximately 2,000 Ismailis in Nairobi, whose forefathers originally settled in the city approximately 150 years before from Western India. Through the guidance and leadership of The Aga Khan IV, the Ismaili community in Kenya has worked to develop religious councils and boards which provide assistance in various areas, such as education, child development and counselling. The present study will take place within the context of the Ismaili community.

2.1 Aims of the Current Research

The aim of the current study is to explore how Ismaili adults living in Nairobi, Kenya understand their experience of depressive symptoms in terms of their religion[1]. The study will also explore how this population uses aspects of their religion to cope with the depressive symptoms.

2.2 Research Questions

In this study, two research questions will be addressed. These are:

1) How do Ismaili adults understand their personal experience of depressive symptoms in terms of their religion?

2) How does their religion influence the way they cope with their personal experience of depressive symptoms?

[1] The Ismailis in Kenya are descendants of early immigrants from India, who were following a specific practice of Ismailism known as *Sathpanth* Ismailism. This has continued over the generations and today, Ismailis in Kenya identify themselves as *Sathpanth* Ismailis. Therefore, all reference made to the religion of the Ismaili participants of the current study refers to the practice of *Sathpanth* Ismailism.

3. Methodology

3.1 Study Design

Qualitative research was selected as the research method for this study. According to Harper and Thompson (2012), qualitative approaches enable the understanding of process, and are centered on detailed readings of experiences rather than establishing causal relationships or quantifying the size of a construct. Qualitative researchers therefore attempt to understand the meaning that people make out of their lived experiences by gathering information personally and engaging in this process. Qualitative research was seen as the most suitable design for this study as it allowed participants to articulate their experiences and talk about related thoughts and feelings. Not only did this allow participants to express themselves in the context which the research was being conducted, but it also enabled the researcher to gather data as it emerged from the study.

3.2 The Researcher

Being an Ismaili adult living in Nairobi, the researcher had a personal interest in conducting this study. Through service rendered as a counsellor on the Community Counselling Services (CCS) and having learned of the rise in cases of adult Ismailis experiencing depressive symptoms, the researcher was keen to investigate how faith influences the way they cope with their experience. Additionally, being a counselling psychologist, the researcher was interested in understanding the relationship between Ismailism and experiences of depressive symptoms experienced within the community, and the possible interplay between the two constructs. Being an Ismaili, the researcher could more readily understand certain religious and cultural concepts being described, and also quickly establish a level of trust where participants could feel comfortable to share their experiences. Additionally, the role of the investigator helped the researcher to understand how the results from the current study could be used to help inform clinical practices regarding treatment for depressive symptoms among adults in the Ismaili community (see Appendix C for the researcher's epistemological position).

3.3 Participants

A total of three female and three male Ismaili adults were interviewed about their experiences of religion when going through significant depressive symptoms. The interviews were conducted in English and took place in settings chosen by the participants,

which, in all cases except two, was the person's own home. Participants were aged between 28 and 57 years old and were living in Nairobi. Four participants reported experiencing the start of their symptoms approximately one and a half years prior to the interview date, one participant approximately two years prior, and one participant approximately one year prior (see Appendix D for a summary of participant information). By the interview date, all participants expressed feeling recovered from their condition. It is important to note that throughout this research and all additional documents, participants' original names have been replaced with pseudo-names for confidentiality.

The reason for selecting six participants was because studies adopting the Interpretive Phenomenological Analysis (IPA) method generally requires between six to eight in-depth interviews to obtain sufficient data (Larkin & Thompson, 2011; Smith, Flowers, & Larkin, 2009). The rationale behind the selection of both genders was to study a more representative sample of the Ismaili community. Nairobi was the city selected because it has always comprised the largest adult Ismaili population in Kenya. This time frame of six months to two years for experiencing significant depressive symptoms was so that participants could remember their experiences more easily. The ability to speak English was an important criteria primarily because parts of participant's reporting would otherwise be lost in translation, and this would affect the accuracy of the results.

3.4 Inclusion and Exclusion Criteria

The following criteria were applied to determine eligibility of participation in the study:

1. Ismaili Muslims living in Nairobi.
2. Between 18-65 years old.
3. Have experienced significant depressive symptoms in the past six months to two years.
4. Have English proficiency.
5. Able to provide written consent to participate in the study.

Individuals were not be eligible to participate if they met the criteria below:

1. Unable to provide consent to participate in the study.
2. Unable to communicate in English.

3.5 Materials

Accounts of participants' experiences were gathered through semi-structured interviews, using a form called the 'The Interview Topic Guide' (Appendix E). The reason for selecting semi-structured interviews is because they provide enough structure to guide the participant around their experiences of religion and depressive symptoms, but also provide enough flexibility to discuss new questions brought up during the interview.

3.6 Ethics Approval

Ethical approval was initially obtained from the University of Leicester Ethics Committee (Appendix F) before commencing any aspect of the study.

3.7 Procedure

Following ethical approval of the study, the researcher prepared an Information Poster (Appendix G) of this study in order to recruit participants. This poster was put up in the Ismaili *Jamat Khana* on a public notice board that is viewed by all attendees to the *Khane*. There was no permission process required for this, as the researcher was an Ismaili. Interested individuals contacted the researcher and received a Letter of Information (Appendix H) and a Participant Information Sheet (Appendix I). Both documents explained details of the study including the reason for conducting the investigation, methodology, ethical considerations, as well as potential benefits and disadvantages. Interview dates were arranged with six individuals who agreed to participate, and who all met the inclusion criteria. All interviews were individually conducted on a day, place and time that was convenient for each participant. On the day of the interview, the participant had the opportunity to ask any further questions about the study, and signed a Consent to Participate Form (Appendix J) before proceeding with the interview. The interviews lasted approximately 45 minutes to an hour and all participants consented to have their interviews audio-recorded.

3.8 Data Analysis

A thematic and step-wise approach was taken to analysis of the interviews as recommended by Smith et al. (2009). This approach, Interpretive Phenomenological Analysis (IPA), involves exploring how people make sense of their major life experiences. It is phenomenological in that it is concerned with exploring experience in its own terms, and IPA research aims to engage with the reflections people make about the significance of

their experiences. IPA is an idiographic approach that uses a double hermeneutic approach where by the researcher interprets the participants' interpretations of their experiences (Smith, et al., 2009). The IPA approach was chosen as the most suitable approach for analysis for the current study as the study was exploratory in nature, had a focus on individuals' lived experiences, and would fit best with a flexible approach that would allow for the exploration of various aspects of individuals' experiences while still maintaining their richness.

Using the IPA approach, the researcher began with transcribing the interview data. Reading each transcript to try and embed herself in the participant's experience. The researcher proceeded to conduct a line-by-line analysis of every participant's account, highlighting comments that had descriptive, linguistic and conceptual focuses to them. During the conceptual analysis, the researcher began coding the highlighted comments, with a focus on participants' understanding of the issues they were discussing (see Appendix K for an example of coding in the current study). The researcher repeated this step twice more to validate the formulated meaning and promote trustworthiness in the results. The researcher also made note of similarities and differences within the comments and codes between the transcripts.

Next, emerging themes were uncovered by combining codes of similar content into groups so that deeper, underlying meanings could be obtained. This step also helped the researcher manage the large volume of detail from the data gathered. The participants' experiences and the researcher's intuitive interpretations were reflected in the themes that emerged. Exploring connections between the newly formed themes was the next step in the analysis. The researcher did this by typing and printing out all the themes on a separate paper and moving the themes around on a large space to explore spatial representations of how the themes related to each other. The researcher noted any similarities and differences that emerged from the themes during this process. The themes were then categorized into 'super-ordinate' themes, which represented encompassing titles of a group of related 'sub-ordinate' themes. From this analysis then, four super-ordinate themes and 13 sub-ordinate themes emerged, which are explained in greater detail in the Results section of this report.

3.9 Quality Issues

A central component in qualitative research is ensuring the quality of the study itself (Smith et al., 2009). In an attempt to ensure this, the researcher took several steps as recommended by Yardley (2008). The first step was to clarify her own position as a researcher and an Ismaili, as well as to discuss the epistemological position taken in the current study. The researcher also used reflexivity to not only understand her personal interests and how they may influence the research process, but also to help ensure that the study was grounded in participants' own accounts.

Reflexivity was also important in helping the researcher understand and become aware of her own position as a member of the Ismaili community, and how this affiliation might have influenced the conduct of the interview and interpretations of participants' experiences. For instance, the researcher was aware that being a member of the same religious community as her participants enabled her to more quickly establish a level of trust where participants felt comfortable and safe to share their experiences in the interview. Second, it made it easier for the researcher sensitize herself to the research study context by respecting the participants during the interview and empathizing with them. Third, the researcher easily understood religious and cultural concepts discussed by participants during the interview, which in turn made participants feel more comfortable to express themselves. However, being a member of the same religious community as her participants also presented certain limitations. For example, it is possible that participants may have been reluctant to express attitudes, thoughts or experiences which they felt may be negatively judged or rejected by the researcher. Second, being a member of the same religious community would make it easier for the researcher to make assumptions about the participants' experiences of religion. Third, having clinical knowledge of depressive symptoms would make it easier for the researcher to make assumptions about participants' experiences of depressive symptoms. The researcher therefore had to be careful to avoid making such assumptions, and instead, to simply be a neutral and open listener to her participants' experiences.

The second step as recommended by Yardley (2008) was to demonstrate sensitivity to the context of the study by empathizing with the participant, putting them at ease, and being respectful should any interactional difficulties have arisen during the interview. This

sensitivity to the context continued through the analysis process. In the third step, the researcher personally committed to making sure that participants all felt comfortable while they were being interviewed, and she also attended closely to their accounts. Furthermore, the researcher selected a highly appropriate and homogeneous sample for the current study, to ensure rigor of the investigation.

In the fourth step, the researcher maintained transparency by outlining the research process. This included describing the selection of participants, the interview and analysis processes, and aligning the write-up closely with IPA principles. Additionally, the researcher kept a journal to to record her thoughts and reflections about the research process. Specifically, the journal helped to maintain a sense of inner balance by remaining open during the interview process, while still attending to and exploring the researcher's thoughts, experiences and feelings. In the journal (see Appendix L for an extract of the researcher's journal), she recorded her feelings about the interview process, and noted down thoughts about the participants' accounts and how they impacted her. Additionally, the researcher was aware of the current literature in the field of the current study, and also made note of the importance of the current study for clinical issues, as well as for service during the research process. Interpretations were also checked to avoid over-generalization or over-simplification by searching for contradictions within the data, and discussing interpretations with a fellow doctoral student and her supervisor.

4. Results

Following the analysis, four super-ordinate themes and twelve sub-ordinate themes emerged which were prominent across the six interviews (Table 1).

Table 1: Summary of Themes

Super-ordinate Themes	Subordinate Themes
Depression: An Experience of Disconnection	External disconnection and depression *"You've lost yourself"* "*Pulling back"* from social interactions with the religious community
Initial, Negative Interactions Between Religion and Depression	*"God did this to me"* *"It made it worse"*
Positive Interactions with Religion as Facilitating the Process of Recovery	*"A detachment from my problems"* Calming of the mind "*A little bit of peace"* A feeling of comfort Re-connection with the community "*You start seeing how lucky you really are"*
A New Connection with Religion	*"I've understood religion more now"* A different perception of God *"Religion is an everyday thing"*

Descriptive accounts of the themes are provided below with key quotations to highlight how they have been categorized. Before the interviews, several participants were confused between the terms 'depressive symptoms' and 'depression' and mentioned to the researcher that they simply understood their experience as 'depression.' Thus, to help participants feel more comfortable during the interviews, the researcher used the word 'depression' to refer to participants' experiences of depressive symptoms. The themes and accounts below reflect this.

4.1 Depression: An Experience of Disconnection

The first theme highlighted the relationship between the experience of depression and disconnection. Through the participants' accounts, it came to light that their depression was initially triggered by a disconnect with something or someone significant in their lives. These experiences triggered feelings including bewilderment, confusion, anger, loneliness, and negative thinking, and were further accompanied by feelings of a loss of self where the individual felt an internal disconnect with themselves. Participants also talked about experiencing anger towards God, and how this affected the practice of their religion. They went on to describe how, during the depression, they had little desire to interact with people, and as a result, many disconnected from their religious community.

4.1.1 External disconnection and depression.

All participants described an initial experience of disconnection which appeared to trigger the start of their depression. These consisted of either business failures, death of a significant family member, or the loss of a significant relationship. For Sahir, his depression was triggered by a disconnection with his friends and family. He talked about this and described a feeling of isolation that came with this disconnection.

> *"So most of the depression was because of a feeling of isolation, living in a different part of the city...away from friends, family." (Sahir, 3-4)*

4.1.2 *"You've lost yourself".*

When describing the experience of depression, many talked about persistent negative thoughts and emotions. They also talked about feeling confused, lonely, fearful, and, in particular, feeling disconnected from oneself. This was highlighted in Ali's account, when he described the feeling of having lost himself, and the subsequent confusion, fear and loneliness he felt.

> *"...you just feel that you are lost, like you've lost yourself, and you're trying to find your bearings, or some ground. ...You're trying to find your path again...it can all be very lonely." (Ali, 2-3, 5, 8)*

Aliyana reported feeling a loss of control and frustration with herself over her situation. In her account, the internal disconnect is reflected through her sense of disorientation and feeling that she was *"simply existing"*.

"I just didn't feel in control of how I was feeling and knowing which way to turn...just very disorientated in the way I was feeling, very confused very frustrated with myself. ...I remember going into this little hole and there was no way out, coz I was constantly thinking about how bad things were getting...I felt hopeless...I had no direction...I was just existing." (Aliyana, 2-5, 14-16, 20-21)

4.1.3 *"Pulling back"* from social interactions with the religious community.

Another theme that resounded across most interviews was an avoidance, or *'pulling back'*, of social interactions. While most participants experienced this generally with all social interactions, it also occurred within the context of the Ismaili community. Pulling back from the Ismaili community seemed to both reflect and perpetuate the social disconnect participants experienced, and this in turn affected their attendance at the *Khane,* which is the Ismaili house of prayer and the most concentrated meeting point for Ismailis. Rafik's account captures this theme, mentioning how he avoided people and their energies.

"I didn't want to go to Khane because I didn't want to interact with people. I felt negative and withdrawn...and I didn't want to be around others and their energies and their judgments." (Rafik, 21-23)

According to Nooreen's account, her attendance at the *Khane* was affected to a lesser degree than Rafik's, however, she also avoided social interactions with other Ismailis as it reminded her of her aloneness.

"...when I was really depressed, I would just go off [from Khane]....even on big days, I didn't want to go to Khane because there were so many people...it reminded me of my family, and I missed my family, and it brought home to me that I was all alone, and I didn't want to face everyone at that time, so I pulled back." (Nooreen, 85-88)

However, not all participants pulled back from social interactions with community members. For Ali, mixing with Ismailis at the *Khane* actually helped him to feel connected, to broaden his social network, and to get involved in activities that would foster social network, such as volunteering.

"...you go [to Khane] and you meet people...and if sometimes you have a question, somebody may relay something to you which you are going through or an answer you get just from having conversations with people. ...You meet new friends too, maybe you get involved in activities, voluntary service. ...And that [socializing] helped,

because...you are now interacting with people, you're managing yourself...from the social perspective, it allows you to not be alone." (Ali, 47-51, 54-57)

4.2 Initial, Negative Interactions Between Religion and Depression

Interactions with religion at participants' early stages of depression revealed interesting influences on participants' ability to cope with their depression. It appeared that, in searching for reasons for their depression, participants initially blamed God and felt it was a punishment from God. They went on to discuss how these perceptions and feelings affected their practice of religion, led to a further disconnect with themselves and their religion, and subsequently intensified their experience of depression.

4.2.1 *"God did this to me."*

Five participants reported that in the early stages of their depression, they felt that God was responsible for the depression. They felt that God had allowed it to happen and subsequently expressed feelings of frustration, confusion and anger. They also expressed an initial impression that the depression was a punishment from God, and this, together with the feelings of anger, negatively impacted the practice of their religion. Nooreen highlighted this with an element of self-blame.

"Initially I was very angry at God...I thought what did I do wrong? Why is He doing his to me? I had helped everybody, I had done everything I thought was right and now I was in the depths of depression. ...on...big days, everyone would go [to Khane] and gather to pray to the Imam and I wouldn't go." (Nooreen, 101-103, 116-118)

Jamila's account also reflected confusion, anger and blame towards God, while questioning who God is with a tone of bewilderment. In addition, she commented on how this affected her practice of prayer.

"When I started my depression, I felt so angry at God. ...I was like God did this to me. They say God is good, God is love, God is patient, so if God is good and God is love, why did He take the best part of my life away? At first I didn't feel like going to Khane because I thought why did He do this to me." (Jamila, 30, 113-115, 142-143)

In his account, Sahir attempted to understand the reason for his depression by critically examining his own actions. He talked about karma but used his experience of depression to challenge this concept. The impression that the depression was a punishment from God was

evident, and Sahir eventually directed the cause of the depression back to himself. He ended by commenting on how this affected the practice of his religion.

> *"I've always thought of myself as being someone that lives ethically...and that's all part of religion. ...and so when you go through a bad time in your life, the first instinct that I had was to blame it [religion] and say, well I'm trying hard to be good, I'm trying to do good things and why is this happening? ...If you think of karma...its just that do good and good happens to you...and that reflects then back to God, and your Imam. Its like why aren't you helping me? Why are you making me go through such a hard time? ...I remember at one point thinking that I must have done something wrong to have all this happen to me. ...It pushed me away from it for a while, so I wouldn't go to Khane as often as I would normally go...for a while actually it just stopped." (Sahir, 55-57, 58-60, 67-75)*

4.2.2 *"It made it worse."*

The result of this initial interaction with religion was that it intensified participants' experiences of depression. Sahir, for example, described the relationship this had with his depression.

> *"It made it worse, coz you're not only depressed, but you're really angry and your mind is not thinking in the positive...like you're focused on all this negative aspect that's happened in your life, because the divine that you're trying to connect to, you're pushing away from it rather than trying to connect with it." (Sahir, 88-91)*

At the end of the interview, two participants went on to discuss how one's frame of mind and level of motivation to heal can affect a person's ability to experience the benefits of religion. For example, during his interview, Ali explained that as one's depression worsens, it leads the person into a very negative state. At that point, their objectivity is marred and they are unable to experience the benefit of practicing their religion.

> *"At that point, I think religion doesn't help because you can't think objectively, or clearly, so you wont even function properly, or see anything in its right sense...there's a certain point where if you cross, religion wont help...you need to be in a certain frame of mind where you can realize it [religion], and see religion and get the benefit off of it." (Ali, 177-175)*

4.3 Positive Interactions with Religion as Facilitating the Process of Recovery.

As participants continued to experience negative interactions with their religion, their practice of it further reduced. It was not until an external intervention took place which gradually helped them to begin a journey of recovery from depression. For two participants this intervention involved assistance from close friends and family members, and for four participants, this involved attending therapy. Following this, all participants reported that they did begin to use religion to help cope with their depression, and that this facilitated the recovery process. Different participants described relying on different religious practices, several of which overlapped. One particular practice, volunteering, was talked about by all participants, and other practices were discussed by over half the participants. Several practices also helped them in more than one way.

4.3.1 *"A detachment from my problems".*

Several participants talked about experiencing a sense of detachment from the depression through prayer. They described how prayer enabled them to emotionally distance from the situation. Rafik's account reflected this point when he talked about being able to detach himself from his situation and place his worries on God, through prayer.

> *"What was helpful about the prayer was that I would...basically detach myself from the situation and basically...whatever circumstances and whatever happened in life, I would place my stresses and anxieties on God and let Him worry about it...so it allowed me to not get so emotionally attached to the situation." (Rafik, 37-40)*

Nooreen also experienced detachment from her problems through prayer. For her, she felt it allowed her to see herself through a broader perspective, one that did not define her by her problems.

> *"Praying helped me to see that I was bigger than my problems...it created a separation, like a detachment from my problems. So by the end, I felt that I was me, not my problems." (Nooreen, 46-48)*

4.3.2 Calming of the mind.

Participants described meditation as a practice that helped them to calm their mind down. Meditation seemed to not only clear their mind but enable them to have greater control over their thoughts. Quotes from Sahir and Nooreen's accounts capture this point.

"Meditation was something that helped...it helped clear my mind. Not always easy coz sometimes your mind always fires around, but it just helps to calm the nerves down." (Sahir, 130-132)

"It [meditation] calmed me...it made me slow my thoughts down so I could think better about things." (Nooreen, 71-72)

However, for some participants, meditation served additional purposes during the recovery process. For Sahir, meditation seemed to help him better understand the workings of life and develop an acceptance towards that.

"...I find it [meditation] is a way of just releasing and letting go of all that built up anxiety within you....it helps you feel a sort of acceptance that there's things that happen and that are beyond your control, there are reasons for it and there is no harm." (Sahir, 198-199, 202-204)

4.3.3 *"A little bit of peace".*

In addition to religious practices, the *Khane* itself was described as a physical space of peace. They talked about their experiences of being in this 'environment' that helped them to feel peaceful and calmer, and gradually experience positive changes in themselves. Jamila and Sahir's accounts capture this sense of peace which is experienced by simply sitting in the *Khane*. For Sahir, this experience further influenced his depression by helping him to process it and change his thinking over time.

"When I go to Khane...I sit there to get the peace, positive energy." (Jamila, 70-71)

"When you're in Khane, in the prayer hall...you're in this environment that is peaceful, it's calming, it's quiet...so there's a little bit of peace...when you're depressed and you're sitting in this environment [Khane], you're trying to work through that process, just being in that environment makes you think differently over time." (Sahir, 141-145, 199-202)

However, being in the *Khane* was not the only means of experiencing a sense of peace. Several participants talked about interacting with nature as a practice which they considered religious and, which gave them a feeling of peace within themselves and about their

situation. For Aliyana, it was solitary forest walks that gave her this peace, and being with nature was associated with renewed life.

> *"I have this one thing...that's been so effective...so I go to the forest to do my walks, one and a half hours by myself and for me that's my time just to be able to reflect...for some reason, every time I walk, I feel reborn, I feel so much peace being connected to nature...its a gentle way to remind myself that you're still part of a bigger picture." (Aliyana, 133-137)*

For Nooreen, being in nature helped them feel closer to God and this facilitated the recovery process through the sense of peace and calm they experienced.

> *"Being in touch with nature helped a lot. I feel that was part of God's creation, so just being in touch with nature was very soothing to me." (Nooreen, 92-93)*

4.3.4 A feeling of comfort.

Several participants talked about conversing with God. Specifically, they found themselves drawn not to ritualistic prayer, but to open and honest conversations with God where they could freely express their thoughts and feelings to Him, and feel a sense of comfort as a result. Jamila talks about being able to express herself openly with God through these conversations.

> *"I started talking to God, not praying, but just talking. ...I talked openly with God." (Jamila, 39-40)*

As participants continued to talk about these conversations, they expressed a value for them and an acknowledgment of how much they had assisted them in their recovery process, and in particular, how they had provided a feeling of comfort for them.

> *"It was the one thing that gave me so much joy and even comfort, coz like, every time I walked out [of Khane] I would reflect on where I started and where I was, so I would always walk out feeling a lot better than when I walked in." (Aliyana, 66-68)*

In addition to alleviating their depressive symptoms, the conversations also influenced their religion. Ali sense of comfort is expressed in his own assurance that a higher being was there to listen and support him.

> *"...you feel comfortable knowing that you can share and open your heart to Him and somehow somebody is there to listen to you and they may sort your issues out." (Ali, 111-113)*

4.3.5 Re-connection with the community.

As mentioned earlier, at the initial phases of the depression, most participants experienced a disconnect with themselves, God and the religious community. However, during the recovery process, re-connections with these aspects appeared to facilitate their recovery in different ways. In Sahir's account below, he expresses surprise at how genuinely people cared for him when he resumed attendance at the *Khane*.

> *"I started going to Khane again and interacting with people and socializing and once I started that people in Khane would come to me and say where have you been? We've missed you! ...It was like ok, so I'm not really alone in this, there are people that care, and I'm surrounded by people who genuinely want to make sure I'm ok." (Sahir, 109-111, 114-116)*

Nooreen also found benefit in interacting with the community as she began recovering from the depression. For her, these interactions helped her experience a return to a sense of normality.

> *"Once I started feeling a little better, I was more available to interact with other people...when I was feeling better, I would stop by, I would have a little chat, if someone stopped to talk to me...I would feel good about it, and that helped me feel that I am ok, I'm getting back to normal." (Nooreen, 62-66)*

However, not all participants had positive experiences in socializing with the community. For two participants, the community was viewed separately from the religion, where attending the *Khane* was strictly for purposes of practicing one's religion and not for socializing. For these participants, there seemed to be an underlying theme of feeling judged by community members. This is reflected in Rafik's quote below.

> *"Mixing with everyone and saying hi, how's this, how's that, has never really appealed to me. I don't like the judgments they have and the negative impressions they give. Even now, I don't talk to people. I go in Khane, I do my thing, I say my prayers and I leave." (Rafik, 138-141)*

4.3.6 ***"You start seeing how lucky you really are".***

Volunteering had a profound impact on the process of recovery for all participants. Each one described how they engaged in acts of service towards the less fortunate in the

community. Volunteering benefited them in unique ways, but primarily, it seems to help them appreciate what they had and realize how lucky they were.

> *"...it [volunteering] helped to make me stop thinking about the situation...when you're volunteering, you're focused on serving...you're not thinking about yourself, and you start seeing how lucky you really are." (Rafik, 61, 63-65)*

Sahir discussed volunteering in relation to his religion, commenting on how Ismailism encouraged this service to all members in the community. For him, volunteering enabled him to view his problems from a bigger perspective and helped him to appreciate other struggles people experience.

> *"Our religion has always been very giving...and it's [volunteering] something that I got involved in...and in trying to help others you realize that there are people worse off that need more help, and it's a little bit of taking the focus off of your problems and looking at the bigger picture." (Sahir, 160-161, 163-165)*

For two participants, volunteering helped them in other ways. For instance, Aliyana found it to help her to feel more connected to the community.

> *"The only thing that I did do for a while was volunteering. ...I just did what I could do to help, and it still really helped...because...I was also trying to give back at something, but also keep myself connected in some way to the community, because I was feeling such a disconnect." (Aliyana, 118, 123-126)*

4.4 A New Connection with Religion

Participants also talked about how their experience of depression and recovery from it positively influenced their practice of and connection with religion. Their accounts indicated that they experienced a new bond with their religion, where they embraced it, developed a deeper awareness of the importance of their religion, and a deeper trust in God.

4.4.1 *"I've understood religion more now."*

In particular, participants discussed understanding their religion better as well as the deeper meaning behind the practice of certain rituals.

> *"I think I've found more meaning and I understand it better...I found more meaning in knowing what I'm doing, why I do certain practices in religion." (Ali, 105-106)*

Aliyana tied the process of connecting with her religion to her relationship with herself.

"I've understood religion more now after the depression....as I was going through therapy I was feeling like I was starting to understand a lot of the things that were happening was because of my relationship with myself, and then I went back and started to become more aware of the religion...so the teachings that we have started to make sense now...so I feel like having gone through the depression and because of the way I came out of it, I feel like it kind of brought for me the things that I've been taught but never made sense to me...now they all make sense." (Aliyana, 27-35)

Aliyana and Ali also described how this new understanding positively influenced the practice of their religion.

"...I have more religion now, because I feel like I have a better understanding of all that we were taught, I feel like now I connect with it. When I was younger it was forced on me...like, you have to pray, you have to go to Khane...now I've understood it and I've embraced it to practice it." (Aliyana, 76-79)

"...I found that I became more committed once I understood what I was doing and why I was doing." (Ali, 115-116)

4.4.2 A different perception of God.

At this point, participants began to see God though a more positive lens. They no longer talked about feeling angry towards God or punished by Him. Rather, they discussed the nature of God and the role they believed He was playing in their lives in a more favorable light, using terms that emphasized a more personal and amicable relationship with Him. This is reflected in Sahir's statement below.

"...there's no one there standing there and saying you're going to suffer today, you know, there's no judging." (Sahir, 186-187)

Jamila also initially expressed anger and disappointment with God during the early experiences of her depression. However, later in her interview, she began to describe God as a more supportive and benevolent force in her life.

"I began to see that God really is love, God is kind, and He's good. He's been good to me." (Jamila, 123-124)

4.4.3 *"Religion is an everyday thing."*

Towards the end of the interviews, most participants talked about the meaning religion had in their lives. They described it as a part of life rather than as a coping mechanism. Having recovered from the depression, they saw it as a path that, ideally, needs to be walked on regularly, a practice of worship that should become a part of people's everyday life, and not only serve as a coping strategy in times of hardship. This is captured clearly in Sahir's account.

> *"Ideally, they [other Ismailis] should use them [religious practices] whether or not they have depression...Religion is an everyday thing, I mean you don't... just say oh when things go wrong now I need to pray...it can't work that way, it has to be an everyday thing." (Sahir, 211, 213-216)*

Rafik's account also reflected this theme, but for him, he understood it through an intertwining of the spiritual and material.

> *"...our religion says very clearly that the worldly and spiritual are inseparable...and I believe it now...you can't separate your religion from your daily life...it just becomes a part of my life, blended together in your existence." (Rafik, 113-115)*

Participants went on to give specific examples of how religion became part of their everyday lives. For Rafik, this included engaging in private prayer outside of prayer times, applying religious teachings to work situations and for personal development.

> *"...now, I pray all the time, I drink Nyaaz [holy water] at home now, not just in Khane...like, when I'm sitting in Khane I'll remember something specific in the Farmans and then I'll go home or go to work and try and practice it so I can become a better person. So in that way, my religion is...is blended with my everyday life." (Rafik, 118-122)*

5. Discussion

The aim of the current study was to explore how Ismaili adults living in Nairobi understand their experiences of depressive symptoms in terms of their religion, as well as to explore how this sample population used aspects of their religion to cope with their symptoms. The results of the current study indicated that depressive symptoms, as experienced by this sample, was a process of external and internal disconnection. During their depressive symptoms, they experienced a social disconnect with their religious community which affected their attendance to the *Khane*. Recovery, on the other hand, was experienced as a process of re-connection. Participants described reconnecting with themselves, God, their religion and the religious community, during which time, they resumed their prayers and interactions with the religious community, and also seemed to develop a more personal and meaningful practice of their religion. Interestingly, participants' interactions with religion was found to have mixed influences on their ability to cope with their depressive symptoms. Specifically, their interactions with religion during the initial stages of their symptoms were more negative and subsequently seemed to intensify their experiences of the symptoms. However, as they began to recover, their interactions with religion became more positive and facilitated the recovery process. Through the process of recovery, participants also developed a more meaningful relationship with their religion, a new perception of God, and described religion as an everyday practice, and not only a coping mechanism during times of distress.

The findings of the current study regarding the relationship between religion and depressive symptoms are mostly congruent with Pargament's research on religious coping. Pargament and his colleagues note the relationship between religious coping and depression can be either positive or negative (Abu-Raiya & Pargament, 2015; Pargament & Abu-Raiya, 2007). For instance, positive religious coping, which is defined as attempts to maintain a loving and supportive relationship with God and to use religious beliefs to re-frame or reduce the importance of personal difficulties (Pargament, Smith, Koenig, & Perez, 1998), has been linked to lower depression levels (Abu-Raiya & Pargament, 2015). However, negative religious coping, which involves beliefs of an ominous view of the world, expressions of a tenuous relationship with God and a struggle to find meaning (Bjorck & Thurman, 2007), has been linked to greater depression levels (Abu-Raiya & Pargament,

2015). The finding is also consistent with other research on religious coping (eg. Ano & Vasconcelles, 2005; Braam et al., 2010; Koenig, 2009; Smith et al., 2003) which highlight the relationship between positive and negative religious coping and mental health, including depressive symptomology. Further supporting Pargament's research was that participants of the current study tended to use positive religious coping more than negative religious coping, an observation that has been made among samples from other religious traditions as well (Abu-Raiya & Pargament, 2015).

However, what was unique to the current study was that there seemed to be a time course in how the interactions with religion influenced participants' depressive symptoms. Specifically, during the early, more intense stages of the depressive symptoms, their interactions with religion influenced their coping more negatively, while in the later, less intense stages of the depressive symptoms, their interactions with religion influenced their coping more positively. Other research has contrasted this by showing that the association between religion and depressive symptoms is higher for individuals experiencing severe life stresses than for those with minimal life stresses (Almeida, 2006). However, a limitation with this research is that it was only conducted among Christian populations and therefore, may not be relevant to the participants of the current study. Thus, one possible reason for the finding of the time course might involve the influence depression has on one's mood, behavior and thought processes. Research conducted among Muslim populations indicates that individuals with high levels of depressive symptoms may experience a lack of pleasure in previously enjoyable engagements, and that this may gradually erode their private and public religious involvements. Furthermore, since an experience of depression often includes symptoms, such as lack of energy and persistent negative thinking, previously religious people are likely to become unable to engage in religious activities. As symptoms alleviate, the person is able to once again interact, feel more positive and engage in socially desirable activities, including religious engagements (Smith et al., 2003).

The second way the current study findings are congruent with Pargament's research concerns the specific religious practices and beliefs that helped the participants cope, and how these were similar to Pargament's negative and positive religious coping methods.[2]

---

[2] Since Pargament is credited for the development of the RCOPE (Pargament et al., 2000), the list of religious coping methods, which are compared to the religious practices of the current study, is drawn from this scale.

Specifically, the results of the current study showed that avoiding social interactions with the religious community, expressing anger towards God and blaming God for allowing the depression to happen, all intensified participants' experiences of the depressive symptoms. These are similar to Pargament's negative religious coping methods, which have also been noted to have harmful effects on depression (Abu-Raiya & Pargament, 2015; Ano & Vasconcelles, 2005). For instance, avoiding social interactions with the community was similar to Pargament's negative religious coping method of Interpersonal Religious Discontent, which involves expressing dissatisfaction and confusion with the clergy or members of that religious community during the stressful situation (Pargament et al., 2000). Having anger towards God was similar to Pargament's negative religious coping method of Spiritual Discontent, which involves expressing confusion and dissatisfaction with God's relationship to the individual during the distressing situation (Pargament et al., 2000). Blaming God for allowing the depression to happen resembled Pargament's negative religious coping method of the Punishing God Reappraisal, which involves viewing the stressor as a punishment from God (Pargament et al., 2000). These consistencies suggest that to this extent, Pargament's research on negative religious coping methods may be applied to other religious traditions, and in this case, to Ismaili adults experiencing depressive symptoms.

One initial, prominent belief among the Ismaili participants was that their experience of depressive symptoms was a punishment from God. This matched Pargament's negative religious coping method of the Punishing God Reappraisal, which has also been cited as a negative religious coping method in Hinduism (Tarakeshwar et al., 2003), Buddhism (Phillips et al., 2012) and Judaism (Rosmarin et al., 2009). Not only does this finding suggest that this may be a common experience for followers of different faiths, but it also points to the importance of an individual's relationship with God, and how this relationship may be brought to light through negative experiences, such as depressive symptoms. Furthermore, given that the Punishing God Reappraisal serves the function of finding meaning and understanding of the problematic situation (Pargament et al., 2000), it is possible that this could have applied to the participants in the current research, where the belief that the depressive symptoms were a punishment from God may have been an initial attempt to understand and find a reason for their experience of it.

It is interesting to note that although the current study found that this belief negatively influenced the Ismaili participants' coping with their depressive symptoms, literature in this area among other Muslim populations indicates mixed findings. For instance, Abu Raiya et al. (2008) found that this coping method was related to both general well-being as well as alcohol use among Muslims living in a Western country. However, Braam et al. (2010) found this method to be linked to higher depressive symptoms and MDD among Turkish and Morrocon Sunni Muslims, while Khan et al. (2011) found no correlation between psychological functioning and this coping method among Pakistani Sunni Muslims. These mixed findings warrant the need for further research to clarify and better understand the implications of the Punishing God Reappraisal on depressive symptoms among Muslim populations.

The findings of the current study indicated that engagement in certain religious practices and beliefs which helped participants to cope better with their experience of depressive symptoms was congruent with Pargament's research on positive religious coping methods. For instance, the most prominent practice used by the Ismaili participants was volunteering, and realizing how fortunate they were and feeling connected with their community as a result. In Ismailism, voluntary acts of service to people or God are considered a part of the religion and are strongly encouraged by the *Imam* (Daftary, 1998). In Pargament et al.'s (2001) research, Religious Helping is a positive religious coping method that serves the function of Gaining Intimacy with Others and Closeness to God, and resembles the Ismaili experience of volunteering very closely. Volunteering as a positive religious coping method has also been noted in other research (Abu-Raiya & Pargament, 2015; Bhui et al., 2008; Phillips et al., 2012; Tarakeshwar et al., 2003). Taken together, these findings highlight the importance of re-connection and feeling a sense of belonging when coping with depressive symptoms. Furthermore, volunteering as a religious coping method was more pronounced in the current study than in other research, possibly because the Ismaili community is a minority faith community and, therefore, an Ismaili's sense of identity, connection and healing might largely involve interacting with and feeling a part of this community.

The use of some religious practices, however, were unique to the current study and did not resemble any of Pargament's positive or negative religious coping methods. Examples

of such practices include meditating and sitting in the *Jamat Khana*. One possible reason for this may be that throughout the history of Ismailism, there has been a strong emphasis on engaging in esoteric practices of the faith, including meditation or attending the *Jamat Khane* for reflection and contemplation (Daftary, 1998; Esmail & Nanji, 2007). Thus, it is possible that Ismailis would be more likely to consider these practices helpful and turn to them during times of distress. A second reason may be that practices such as meditation tend to be more commonly practiced in Eastern and Middle Eastern religions than in Western religions. For instance, meditation is not listed as a Jewish (Rosmarin et al., 2009) or Christian (Pargament et al., 2000) religious coping method, but is found in research on Hindu (Tarakeshwar et al., 2003), Buddhist (Phillips et al., 2012) and Islamic (Aflakseir & Coleman, 2011) religious coping methods, highlighting that religious coping appears to take on different forms across different religious traditions and cultures.

Participants in the current study described how their experiences of depressive symptoms and recovery from it resulted in a new, more personal connection with their religion. These findings are consistent with previous literature. For example, Ferraro and Kelley-Moore (2000) found that individuals with depressive symptoms sought comfort in their religion which increased their apparent religiousness. One possible reason for the finding of the current study might relate to the development of a deeper understanding of religion. For instance, as participants came to understand the meaning and purpose behind certain religious rituals and practices, they could bond with their religion more profoundly and practice it more meaningfully. Ferraro and Kelley-Moore (2000) observed a similar finding which they termed as a process of intensification, whereby as individuals became more engaged in religious involvements their use of religious resources for coping was also promoted. A second possible reason might involve the development of a more personal relationship with God. Specifically, participants' realization that God was not punishing them but in fact helping and supporting them through their recovery process appeared to be a help change their view of and relationship with God to a more positive one. This change seemed to trigger participants to redefine the role of God in their experiences from negative to more positive. A third reason may be that since participants' later interactions with religion did result in positive influences on their coping with depressive symptoms, they not only developed a desire to better understand the practices of their religion, but also to hold

onto this connection as a future support system. A fourth reason might involve the psychological change that took place during participants' recovery process. Specifically, as participants experienced positive changes within themselves, it appears they were more open to understanding the depressive symptoms more constructively, to understanding themselves more intimately and in altering the perception of themselves and God. These changes, which took place on personal, social, cognitive, behavioral and religious dimensions, may have triggered re-connections with the community and facilitated more positive interactions with their religion.

Another point of discussion is that that participants eventually experienced religion as an everyday practice, and not only a coping mechanism during a time of distress. This finding was significant and reflected how religion became interwoven with their daily lives. This was highlighted when participants mentioned the need to attend the *Khane* or pray even in the absence of difficulties, suggesting that religion may serve a higher purpose than resolving material matters for them. This finding is consistent with previous studies. For example, research has shown that for individuals who practice a particular faith, especially the devout, religion is not separated from everyday life and only applied at special times or on special occasions, but is a way of life that is to be sought, experienced, and consistently maintained (Hill & Pargament, 2003). Bhui et al. (2008) also found that Islam had a more all encompassing influence on people's lives than among people of other religious beliefs. Taken together, this may suggest that for Muslims, and particularly for Ismailis, faith is more of a philosophy of life and a part of life, and not a separate reality that one only engages in during times of need or convenience.

A final point of discussion concerns participant differences within the study sample, including differences observed among participants who engaged in therapy, as well as among age and gender. It should be noted that the differences were minor and did not appear to influence the overall findings of the current study. Nevertheless, a discussion of the differences is detailed below. Regarding therapy, it appeared that participants who engaged in therapy seemed to be more introspective, making more frequent references to self-development and self-connection, than participants who did not attend therapy. This is likely to be the case since therapeutic work is a process primarily focusing on understanding, discovering and feeling connected to the self (Gilbert, 2007). Regarding age,

participants' accounts did not appear to vary due to this factor. Additionally, participants' accounts did not appear to significantly vary due to gender. Although some research indicates that Muslim women tend to rely on religious coping more frequently than Muslim men (Abu-Raiya & Pargament, 2015; Khan et al., 2009), other research shows that there is no difference in the use of religious coping methods among Muslim men and women (Ai et al., 2003). Thus, despite these differences, the overall findings of the current study did not appear to be influenced by the demographic characteristics of the sample.

5.1 Conclusion

In conclusion, the findings from the current study support the wider literature which indicates that religious coping plays a significant role in mental health. Further, that religious coping can have mixed influences on their ability to cope with depressive symptoms, which is congruent with Pargament's research. Additionally, the specific religious practices used by the Ismailis showed strong similarities to both Pargament's research and the wider literature on religious coping. The current study also brings to light important points regarding the complex relationship between depressive symptoms and religious coping, how faith-based communities use religious coping when experiencing depressive symptoms, and whether the larger research on Muslim religious coping can apply within the Ismaili context. Additionally, the finding that religion was seen as a part of life for the Ismaili participants draws attention to the way in which religion and life for Ismailis is interwoven. However, it is only through further studies and future investigations in this area that one can better appreciate the deep and powerful complexities of religion, its influence on coping with depressive symptoms, and the implications these findings have on clinical practice.

5.2 Clinical Implications

It is important for clinicians to be aware of the mixed influences of religious coping on depressive symptoms. Thus, when working with Ismailis who are experiencing depressive symptoms, clinicians can pay greater attention to specific beliefs or impressions their clients may have about God and religion, which may have harmful influences on their symptom levels. Further, that these influences may occur more intensely during the early stages of clients' depressive symptoms. Clinicians can also keep in mind that the belief that depression is a punishment from God may serve as particularly strong 'red flag' when

working with Ismailis, calling the need for further discussion and exploration of religious issues in the therapeutic process. Third, clinicians, especially non-Ismaili, need to be mindful that Ismaili clients who may have negative beliefs and impressions about God and their religion may experience reluctance to openly discuss these due to fears of judgment and rejection, disagreement of religious values, or the possible pathologizing of their religious practices by the clinician. Therefore, taking appropriate measures to ensure that clients feel safe and comfortable to discuss these issues at their own pace is an important point for clinicians to consider.

Fourth, given Ismaili adults experiencing depressive symptoms can and do engage with their religion in ways that facilitate recovery, it would be wise for clinicians to incorporate these elements of religious coping into their work with such clientele. Fifth, the finding that Ismailis can ultimately experience their religion as a part of life might aid in the development of more cultural- and religious-specific interventions for this community. Previous studies have supported this notion by showing that clients who receive psychotherapy that included Islamic components, such as prayer and relying on Allah in times of need, responded significantly faster to therapy and showed better adjustment than those receiving standard treatment (Abu Raiya et al., 2008). Sixth, clinicians need to be mindful of the fact that Western defined religious coping methods and their functions may be experienced differently among different faiths. Thus, when non-Ismaili clinicians work with Ismaili clients, it would be helpful to research on and sensitize themselves to these differences, in order to enable a deeper understanding and a more supportive therapeutic relationship with their clients.

5.3 Limitations

The current findings should be interpreted in light of several methodological limitations. First, transferring the research findings to non-Sathpanth Ismailis may be limited as the difference in the cultural practice of religion may inform the way religion influences depressive symptoms. Secondly, transferring the results of the current study to Ismailis of different ages may also be limited as their practice of religion and understanding of depression may vary from that of adults. Third, since the researcher belonged to the same faith-based community as the participants, it is possible that participants may have experienced some reluctance to discuss during the interview any beliefs and impressions

about God, their religion or the community, which they felt might be judged, disagreed with or rejected by the interviewer. Additionally, the findings do not provide information regarding longitudinal effects of religious coping with depressive symptoms among Ismailis. Fourth, it is possible that the sample was representative of people who had an interest in religion. Fifth, considering the interviews took place when participants felt recovered from their condition, it is possible their experiences were remembered more positively. Therefore, the overall influence of religion on depressive symptoms, as experienced by participants' in the current study, may have been reported more positively than it actually occurred.

5.4 Suggestions for Future Research

In regards to future research, it would be beneficial to conduct longitudinal studies examining religious coping and depressive symptoms to determine the long-term influences religion may have on this problem. Second, it would be helpful to carry out further studies on whether a time course exists with the influence of religious coping on depressive symptoms. Third, investigating how depression may influence one's engagement with religion when trying to overcome the symptoms would help better understand the interplay between these factors. This knowledge would be especially helpful for clinicians as it would provide key information for early intervention, particularly for individuals who might engage with religion in a way that may influence depressive symptoms detrimentally. Fourth, it would be interesting to conduct investigations among non-Sathpanth Ismailis, such as Ismailis from China or Afghanistan. If the findings from these studies corroborate those from the current study, it would indicate that the latter would be more transferable to these contexts. If not, one would nevertheless gain a better understanding of the possible interplay between cultural and traditions contexts, religious coping, and depressive symptoms among this sample population. A fifth area of future research is to conduct studies with a different age group within the Ismaili community. The current study sample consisted of adults, and it would be interesting to carry out the same study among younger Ismailis or the geriatric Ismaili population. The findings of these future studies would no doubt expand knowledge of the complex relationship between religious coping and depressive symptoms, add further literature on Ismailis, and better inform therapeutic practices when incorporating religious coping into the healing processes.

References

Abdel-Khalek, A., & Eid, G. (2011). Religiosity and its association with subjective well-being and depression among Kuwaiti and Palestinian Muslim children and adolescents. *Mental Health, Religion & Culture*, *14*(2), 117-127.

Abdel-Khalek, A., & Lester, D. (2007). Religiosity, health, and psychopathology in two cultures: Kuwait and USA. *Mental Health, Religion and Culture*, *10*(5), 537-550.

Abel-Khalek, A., & Naceur, F. (2007). Religiosity and its association with positive and negative emotions among college students from Algeria. *Mental Health, Religion & Culture, 10*(2), 159–170.

Abu-Raiya, H., & Pargament, K. (2015). Religious coping among diverse religions: Commonalities and divergences. *Psychology of Religion and Spirituality, 7*(1), 24.

Abu Raiya, H., Pargament, K. I., Mahoney, A., & Stein, C. (2008). A psychological measure of Islamic religiousness: Development and evidence for reliability and validity. *The International Journal for the Psychology of Religion, 18*(4), 291-315.

Adams, B. (1974). Kin network and the adjustment of the Ugandan Asians. *Journal of Marriage and the Family*, *36*(1), 190-195.

Aflakseir, A., & Coleman, P. (2011). Initial development of the Iranian religious coping scale. *Journal of Muslim Mental Health, 5*(1), 44-61.

Aga Khan. (2002). Inauguration of the Ismaili JamatKhana and center. Retrieved from the Aga Khan Development Network website: http://www.akdn.org/speech/his-highness-aga-khan/inauguration-ismaili-jamatkhana-and-center

Ai, A., Huang, B., Bjorck, J., & Appel, H. (2013). Religious attendance and major depression among Asian Americans from a national database: The mediation of social support. *Psychology of Religion and Spirituality, 5*(2), 78.

Ai, A. L., Peterson, C., & Huang, B. (2003). RESEARCH: The effect of religious-spiritual coping on positive attitudes of adult Muslim refugees from Kosovo and Bosnia. *The International Journal for the Psychology of Religion,13*(1), 29-47.

Amer, M., Hovey, J., Fox, C., & Rezcallah, A. (2008). Initial development of the brief Arab religious coping scale (BARCS). *Journal of Muslim Mental Health, 3*(1), 69-88.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington VA: American Psychiatric Publishing.

Anderson, J. (1964). The Isma'ili Khojas of East Africa: A new constitution and personal law for the community. *Middle Eastern Studies*, *1*(1), 21-39.

Ano, G., & Vasconcelles, E. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*(4), 461-480.

Bhui, K., King, M., Dein, S., & O'Connor, W. (2008). Ethnicity and religious coping with mental distress. *Journal of Mental Health, 17*(2), 141-151.

Bjorck, J., & Thurman, J. (2007). Negative life events, patterns of positive and negative religious coping, and psychological functioning. *Journal for the Scientific Study of Religion, 46*(2), 159-167.

Bocock, R. (1971). The Ismailis in Tanzania: A Weberian analysis. *British Journal of Sociology*, *22*(4), 365-380.

Braam, A., Schrier, A., Tuinebreijer, W., Beekman, A., Dekker, J., & de Wit, M. (2010). Religious coping and depression in multicultural Amsterdam: A comparison between native Dutch citizens and Turkish, Moroccan and Surinamese/Antillean migrants. *Journal of Affective Disorders, 125*(1), 269-278.

Cinnirella, M., & Loewenthal, K. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology*, *72*(4), 505-524.

Clarke, P. (1976). The Ismailis: A study of community. *British Journal of Sociology*, *27*(4), 484-494.

Cole, B. S. (2005). Spiritually-focused psychotherapy for people diagnosed with cancer: A pilot outcome study. *Mental Health, Religion & Culture, 8*(3), 217-226.

Community Counselling Services. (2015). *CCS Statistics*. Retrieved from CCS Statistics Database.

Copeland-Linder, N. (2006). Stress among black women in a South African township: The protective role of religion. *Journal of Community Psychology*, *34*(5), 577-599.

Cummings, J. P., & Pargament, K. I. (2010). Medicine for the spirit: Religious coping in individuals with medical conditions. *Religions, 1*(1), 28-53.

Daftary, F. (1998). *A short history of the Ismailis: Traditions of a Muslim community*. Edinburgh: Edinburgh University Press.

Damji, T., & Lee, C. (1995). Gender role identity and perceptions of Ismaili Muslim men and women. *The Journal of Social Psychology*, *135*(2), 215-223.

Davis, D., Ashby, J., McElroy, S., & Hook, J. (2014). Religious coping, coping resources, and depressive symptoms: Test of a mediation model. *Counseling and Values, 59*(2), 139-154.

Dossa, P. (1999). (Re) imagining aging lives: Ethnographic narratives of Muslim women in diaspora. *Journal of Cross-Cultural Gerontology, 14*, 245–272.

Dossa, P. (1994). Critical anthropology and life stories: Case study of elderly Ismaili Canadians. *Journal of Cross-Cultural Gerontology, 9*, 335-354.

Doyle, D. (1992). Have we looked beyond the physical and psychosocial? *Journal of Pain and Symptom Management, 7*, 302–311.

Eliassen, A. (2013). Religious coping and depression in young adulthood: Effects of global stress exposure and pre-teenage religious service attendance. *Review of Religious Research, 55*(3), 413-433.

Emadi, H. (2005). Nahzat-e-Nawin: Modernization of the Badakhshani Isma'ili communities of Afghanistan. *Central Asian Survey*, *24*(2), 165-189.

Esmail, A., & Nanji, A. (2007). *The Isma'ilis in History*. London, UK: Institute of Ismaili Studies.

Feder, A., Ahmad, S., Lee, E., Morgan, J., Singh, R., Smith, B. W., ... & Charney, D. (2013). Coping and PTSD symptoms in Pakistani earthquake survivors: Purpose in life, religious coping and social support. *Journal of Affective Disorders, 147*(1), 156-163.

Ferraro, K., & Kelley-Moore, J. (2000). Religious consolation among men and women: Do Health Problems Spur Seeking? *Journal for the Scientific Study of Religion, 39*(2), 220-234.

Faigin, C., Pargament, K., & Abu-Raiya, H. (2014). Spiritual struggles as a possible risk factor for addictive behaviors: An initial empirical investigation. *The International Journal for the Psychology of Religion, 24*(3), 201-214.

Gilbert, P. (2007). *Psychotherapy and counselling for depression*. London: SAGE Publications Ltd.

Harper, D., & Thompson, A. R. (Eds.). (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* United Kingdom: John Wiley & Sons.

Harris, J., Erbes, C., Engdahl, B., Ogden, H., Olson, R., Winskowski, A., &…Mataas, S. (2012). Religious distress and coping with stressful life events: A longitudinal study. *Journal of Clinical Psychology*, *68*(12), 1276-1286.

Harrison, O., Koenig, H., Hays, J., Eme-Akwari, A., & Pargament, K. (2001). The epidemiology of religious coping: A review of recent literature. *International review of Psychiatry, 13*(2), 86-93.

Highfield, M. (2001). Spiritual and religious care. In T. Fulmer, M. Foreman, & M. Walker (Eds.), *Critical care nursing of the elderly* (pp. 326-352). New York: Springer

Hill, P., & Pargament, K. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58*(1), 64 –74.

Hodge, D. (2005). Social work and the house of Islam: Orienting practitioners to the beliefs and values of Muslims in the United States. *Social Work*, *50*(2), 162-173.

Hussain, F. (2009). The mental health of Muslims in Britain. *International Journal of Mental Health*, *38*(2), 21-36.

Hussain, F., & Cochrane, R. (2003). Living with depression: Coping strategies used by South Asian women, living in the UK, suffering from depression. *Mental Health, Religion & Culture*, *6*(1), 21-44.

Kassam, T. (1995). *Songs of wisdom and circles of dance: Hymns of the Satpanth Ismaili Muslim saint, Pir Shams.* Albany: State University of New York Press.

Keshavjee, R. (2010). The elusive access to education for Muslim women in Kenya from the late nineteenth century to the "Winds of Change" in Africa (1890s to 1960s). *Paedagogica Historica*, *46*(1-2), 99-115.

Khan, Z., & Watson, P. (2006). Construction of the Pakistani Religious Coping Practices Scale: Correlations with religious coping, religious orientation, and reactions to stress among Muslim university students. *The International Journal for the Psychology of Religion, 16*(2), 101-112.

Khan, Z., Watson, P., & Chen, Z. (2011). Differentiating religious coping from Islamic identification in patient and non-patient Pakistani Muslims. *Mental Health, Religion & Culture, 14*(10), 1049-1062.

Khawaja, N. G. (2008). An investigation of the factor structure and psychometric properties of the COPE scale with a Muslim migrant population in Australia. *Journal of Muslim Mental Health, 3*, 177-191.

Khuwaja, S., Selwyn, B., Kapadia, A., McCurdy, S., & Khuwaja, A. (2007). Pakistani Ismaili Muslim adolescent females living in the United States of America: Stresses associated with the process of adaptation to U.S. culture. *Journal of Immigrant Health, 9,* 35–42.

Koenig, H. (2009). Research on religion, spirituality, and mental health: A review. *The Canadian Journal of Psychiatry, 54*(5), 283-291.

Koenig, H., Cohen, H., Blazer, D., Kudler, H., Krishnan, K., & Sibert, T. (1995). Religious coping and cognitive symptoms of depression in elderly medical patients. *Psychosomatics, 36*(4), 369-375.

Koenig, H., King, D., & Carson, V. (2012). *Handbook of religion and health (2nd ed.)*. New York: Oxford University Press.

Koenig, H., McCullough, M., & Larson, D. (2001). *Handbook of religion and health: A century of research reviewed.* New York: Oxford University Press.

Koenig, H., Pargament, K., & Nielsen, J. (1998). Religious coping and health status in medically ill hospitalized older adults. *The Journal of Nervous and Mental Disease, 186*(9), 513-521.

Kohn-Wood, L., Hammond, W., Haynes, T., Ferguson, K., & Jackson, B. (2012). Coping styles, depressive symptoms and race during the transition to adulthood. *Mental Health, Religion & Culture, 15*(4), 363-372.

Krumrei, E., Mahoney, A., & Pargament, K. (2011). Spiritual stress and coping model of divorce: A longitudinal study. *Journal of Family Psychology, 25*(6), 973.

Larkin, M., & Thompson, A. (2011). Interpretative Phenomenological Analysis in Mental Health and Psychotherapy Research. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101-116). Chichester, UK: John Wiley & Sons Ltd.

Leaman, S., & Gee, C. (2012). Religious coping and risk factors for psychological distress among African torture survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(5), 457.

Loewenthal, K., MacLeod, A., Goldblatt, V., Lubitsh, G., & Valentine, J. (2000). Comfort and Joy? Religion, cognition and mood in individuals under stress. *Cognition and Emotion*, 14, 355-374.

Marcus, M., Yasamy, M., van Ommeren, M., Chisholm, D., & Saxena, S. (2012). Depression: A global public health concern. Report of the WHO Department of Mental Health and Substance Abuse. Retrieved from http://www.who.int/mental_health/management/depression/wfmh_paper_depression_wmhd_2012.pdf

McCullough, M., Hoyt, W., Larson, D., Koenig, H., & Thoresen, C. (2000). Religious involvement and mortality: a meta-analytic review. *Health Psychology, 19*(3), 211.

McFadden, S. H. (1995). Religion and well-being in aging persons in an aging society. *Journal of Social Issues, 51*(2), 161-175.

Morris, S. (1956). Indians in East Africa: A study in a plural society. *The British Journal of Sociology*, *7*(3), 194-211.

Nasr, S. (1985). *Ideals and realities of Islam*. London: George Allen & Unwin.

Oman, D. (2014). Defining religion and spirituality. In R. Paloutzian, & C. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 23-47). New York: Guilford Publications.

Pargament, K. (1997). *The psychology of religion and coping: Theory, research and Practice*. New York: Guilford Press.

Pargament, K., Feuille, M., & Burdzy, D. (2011). The Brief R-COPE: Current psychometric status of a short measure of religious coping. *Religions, 2*(1), 51-76.

Pargament, K., Koenig, H., & Perez, L. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology, 56*(4), 519-543.

Pargament, K., & Raiya, H. (2007). A decade of research on the psychology of religion and coping: Things we assumed and lessons we learned. *Psyke & Logos*, *28*(2), 25.

Pargament, K., Smith, B., Koenig, H., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion, 37*(4), 710-724.

Park, C. L., & Cohen, L. H. (1993). Religious and nonreligious coping with the death of a friend. *Cognitive Therapy and Research, 17*(6), 561-577.

Phillips, R. Michelle-Cheng, C., Oemig, C., Hietbrink, L., & Vonnegut, E. (2012). Validation of a Buddhist coping measure among primarily non-Asian Buddhists in the United States. *Journal for the Scientific Study of Religion, 51*(1), 156-172.

Pirutinsky, S., Rosmarin, D., Pargament, K., & Midlarsky, E. (2011). Does negative religious coping accompany, precede, or follow depression among Orthodox Jews? *Journal of Affective Disorders, 132*(3), 401-405.

Rodriguez Mosquera, P. M., Khan, T., & Selya, A. (2013). Coping with the 10th anniversary of 9/11: Muslim Americans' sadness, fear, and anger.Cognition & emotion, 27(5), 932-941.

Rosmarin, D., Pargament, K., Krumrei, E., & Flannelly, K. (2009). Religious coping among Jews: Development and initial validation of the JCOPE. *Journal of Clinical Psychology, 65*(7), 670-683.

Sahraian, A., Gholami, A., Javadpour, A., & Omidvar, B. (2013). Association between religiosity and happiness among a group of Muslim undergraduate students. *Journal of religion and health, 52*(2), 450-453.

Schettino, J., Olmos, N., Myers, H., Joseph, N., Poland, R., & Lesser, I. (2011). Religiosity and treatment response to antidepressant medication: A prospective multi-site clinical trial. *Mental Health, Religion & Culture*, *14*(8), 805-818.

Sherman, A., Simonton, S., Latif, U., Spohn, R., & Tricot, G. (2005). Religious struggle and religious comfort in response to illness: Health outcomes among stem cell transplant patients. *Journal of Behavioral Medicine, 28*(4), 359-367.

Skinner, R. (2010). An Islamic approach to psychology and mental health. *Mental Health, Religion & Culture*, *13*(6), 547-551.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: SAGE Publications Ltd.

Smith, T., McCullough, M., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129*(4), 614-636.

Srivastava, N. (2013, October 1). How the Nairobi attack has shaken Kenya's Indians. *The British Broadcasting Corporation.* Retrieved from http://www.bbc.com/news/world-asia-india-24327554

Stanley, M., Bush, A., Camp, M., Jameson, J., Phillips, L., Barber, C., &…Cully, J. A. (2011). Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging & Mental Health*, *15*(3), 334-343.

Stolzenberg, R., Blair-Loy, M., & Waite, L. (1995). Religious participation in early adulthood: Age and family life cycle effects on church membership. *American Sociological Review*, 84-103.

Taylor, R., Chatters, L., & Abelson, J. (2012). Religious involvement and DSM-IV 12 month and lifetime major depressive disorder among African Americans. *The Journal of Nervous and Mental Disease, 200*(10), 856.

Tarakeshwar, N., & Pargament, K. I. (2001). Religious coping in families of children with autism. *Focus on Autism and Other Developmental Disabilities, 16*(4), 247-260.

Tarakeshwar, N., Pargament, K. I., & Mahoney, A. (2003). Initial development of a measure of religious coping among Hindus. *Journal of Community Psychology, 31*(6), 607-628.

Trevino, K., Pargament, K., Cotton, S., Leonard, A., Hahn, J., Caprini-Faigin, C., & Tsevat, J. (2010). Religious coping and physiological, psychological, social, and spiritual outcomes in patients with HIV/AIDS: Cross-sectional and longitudinal findings. *AIDS and Behavior, 14*(2), 379-389.

Virani, S. (2011). Taqiyya and identity in a South Asian community. *The Journal of Asian Studies*, *70*(1), 99-139.

Walpole, S., McMillan, D., House, A., Cottrell, D., & Mir, G. (2012). Interventions for treating depression in Muslim patients: A systematic review. *Journal of Affective Disorders*, *145*(1), 11-20.

Wei, D., & Liu, E. (2013). Religious involvement and depression: Evidence for curvilinear and stress-moderating effects among young women in rural China. *Journal for the Scientific Study of Religion*, *52*(2), 349-367.

World Health Organization. (2016). *Depression*. Retrieved from http://www.who.int/mediacentre/factsheets/fs369/en/

Yardley, L. (2008). Demonstrating Validity in Qualitative Psychology. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed) (pp. 257-272). London, UK: SAGE Publications Ltd.

Appendix A

His Highness The Aga Khan IV: A Brief History and Explanation of his Role as the Ismaili Spiritual Leader

His Highness the Aga Khan IV was appointed as the *Imam*, or spiritual leader, of the Ismaili Muslims on July 11th 1957. At that time, he was 20 years old and succeeded the Aga Khan III, his grandfather. The Aga Khan IV is the 49th hereditary *Imam* of the Ismailis, who believe that he is a direct descendant of the Prophet Muhammad (Daftry, 1998).

Since assuming the role of the *Imam*, the Aga Khan IV has primarily been concerned about the well-being of the Ismailis. His role and mandate as the *Imam* has required him to lead the Ismailis in the spiritual interpretation of Islam, and in the improvement of their quality of life and of the societies in which they live (Daftry, 1998).

The figure of the *Imam*, as the religious and administrative head of the community, is central to the Ismaili constitution, which outlines the Ismaili identity. The *Imam* is the sole individual who is empowered to change or revise the constitution. Ismailis possess deep devotion to their *Imam*, affectionately referred to as *Mowlana Hazir Imam*, meaning, 'our lord, the living and present *Imam'* (Nasr, 1985). The *Imam* remains in close contact with his followers, and guides them through his oral and written directives (Daftry, 1998).

Appendix B

The Ismaili Religion - A Brief History and Description of Relevant, Religious Terms

A Brief History of Ismailism

The Ismaili Muslims are a part of the Shia branch of Islam who trace the lineage and religious and spiritual authority of their *Imam*, or spiritual leaders, directly to the Prophet Muhammad. Ismaili Muslims are known as such because following the death of the fifth *Imam*, Ja'far al-Sadiq, the community paid allegiance to his elder son, Ismail-ibn-Jafar, as the legitimate successor. They differ from the majority of the Shia branch of Islam, known as the Ithna 'Ashari, or Twelver Shias, who trace the lineage of their *Imam* through *Imam* Ja'far al-Sadiq's younger son, Musa al-Kazim. The Ismaili sect itself was further divided following the death of the 18th *Imam*. At this time, only the present day Ismaili community accepted the 18th *Imam*'s son, Abu Mansur Nizar, as the next *Imam*, and thus became known as the Shia Nizari Ismaili Muslims. The term 'Ismaili' technically encompasses all sects of the Shia branch which accept Ismail-ibn-Jafar as the rightful 6th *Imam*. However, presently, the term is most frequently used to refer to the Shia Nizari Ismailis (Nasr, 1985).

Ismailism was formed in the mid 7th century AD and by the 14th century, the religion had spread across Arabia, Persia, Afghanistan, China, and the Indian subcontinent. In the case of Ismailis in the Indian subcontinent, the dominant Hindu culture and religion notably influenced the practice of Ismailism there. Conversion from Hinduism to Ismailism took place mostly during the 11th and 12th centuries AD, and while convertees took to this new religion, the symbolism of the rich, spiritual Hindu culture was integrated into the religion. This blended practice of faith was as *Satpanth* [Ismailism], literally meaning 'true path.' *Satpanth* Ismailism, then, is what accompanied the Indian Ismailis as they left India and found new homes for themselves in East Africa in the early 1900's (Kassam, 1995).

An important aspect of Ismailism, which is also evident in *Satpanth* Ismailism, is its emphasis on the esoteric, or *batin,* dimension of Islam. This referring to knowledge that is accessible only to selected few who possessed the insight and understanding to perceive the hidden meanings. Throughout the history of Ismailism, the function of teaching the esoteric interpretations of the Quran has been undertaken by the Ismaili *Imams,* and there are numerous texts and writings by Ismaili missionaries which teach this esoteric meaning (Daftry, 1998).

Description of Relevant, Religious Terms Used by Satpanth Ismailis and their Meanings

Imam - Spiritual Leader (Daftry, 1998)

Mowlana Hazir Imam - Our lord, the living and present *Imam* (Daftry, 1998)

Jamat Khana or *Khane* - Congregational house of prayer (Daftry, 1998)

Dua - Thrice daily ritualistic prayer mandated for all Ismailis (Esmail & Nanji, 2007)

Farman - Oral and written directives of guidance from the *Imam* to his followers, focusing on areas such as spiritual and religious responsibilities, education, personal conduct, health, and economic enterprises. (Daftry, 1998)

Ginan - Devotional hymns (Daftry, 1998)

Tasbih - (noun) - Rosary

(verb) - Prayer involving reciting the 99 names of Allah, the name of the Prophet Muhammad, or the names of the *Imams* (Nasr, 1985).

Salwat - Prayer that beseeches God to shower His blessings on man. This prayer is made in the name of the Prophet Muhammad and the *Imams* (Esmail & Nanji, 2007).

Baitul Khayal or *Bandgi* or *Parode* - A meditation session held every morning at the *Jamat Khana* (Esmail & Nanji, 2007)

Pirs - Ismaili missionaries (Daftry, 1998)

Majlis - Religious ceremony held at the *Jamat Khana* (Daftry, 1998)

Appendix C

The Researcher's Epistemological Position and the Method of Analysis Used

The epistemological approach of phenomenology was used for the purpose of the current research. One main reason for this was an interest the researcher had in exploring subjective experiences of individuals in regards to religious coping and depressive symptoms from their own perspective. This interest could be explored most effectively with this approach, as the focus of phenomenology does not lie in the accuracy of what a person says, but rather, in understanding the person's past from their perspective. A second reason is that the phenomenological approach is flexible as it assumes a certain degree of correspondence between what an individual says and what he/she experiences, which fit the researcher's study. Additionally, the phenomenological interpretative approach, and not the phenomenological descriptive approach, was selected for the current study as it would enable the researcher to go deeper than the content to try and find meaning through interpretation (Harper & Thomson, 2011).

The method of analysis for the current study was Interpretative Phenomenological Analysis (IPA), and this selection was made for several reasons. First, the research questions in this study were focused on how participants experienced religion during depressive symptoms, and IPA primarily explores how people make sense of their major life experiences (Smith, et al., 2010), indicating a fit between IPA and the research aims. IPA also fit well with the researcher's epistemological position of phenomenology, because it allowed for various interpretations of the subjective meaning of the data which was shared by the researcher as well as the participant. Further, data in the current study was gathered through semi-structured interviews, since this technique provides enough structure to the discussion to remain on topic, while allowing for flexibility to expound on subjective experiences and other related topics that may come up (Smith et al., 2010).

It is also important to note that the researcher was not only aware of her own affiliation with the Ismaili community, and therefore, with the participants as well, but also how this affiliation might influence the interpretations made of participants experiences (Smith et al., 2010). For example, the researcher was aware that being a member of the participants' religious community enabled her to establish a level of trust more quickly where participants felt safe and comfortable to share their experiences. It also made it easier for her to be sensitive to the context of the research study by showing respect to the participants during the interview, empathizing with them and making them feel comfortable. Third, she could more easily understand religious and cultural concepts used by the participants, which in turn would make it more comfortable for participants to express themselves. However, being a member of the same religious community as the participants also presented certain limitations. For example, it is possible that participants may have been reluctant to express any attitudes, thoughts or experiences, which they felt would be rejected or judged negatively by the researcher. Also, it would be easier for the researcher to make assumptions about the participants' experiences of religion and depressive symptoms, since both were Ismailis and the researcher had clinical knowledge of

depressive symptoms. The researcher therefore had to be careful to avoid making such assumptions, and instead, to put aside her own interpretations, explanations and experiences and simply be a neutral and open listener to her participants' experiences.

Appendix D

Summary of Participant Information

Participant Pseudo-name	Gender	Age	Approximate Start of Depressive Symptoms (in relation to the interview date)	Approximate Depressive Symptoms Time-Frame	Attended Counselling Sessions?
Jamila	F	28	2 years prior	1.5 years	Y
Sahir	M	31	1.5 years prior	1 year	N
Rafik	M	34	1 year prior	7-8 months	Y
Aliana	F	38	1.5 years prior	10-12 months	Y
Ali	M	49	1.5 years prior	8-10 months	Y
Nooreen	F	57	1.5 years prior	1 year	N

Appendix E

The Interview Topic Guide

Introduction

- Provide background to research/Purpose of interview
- Discuss Confidentiality
- Request Signed Consent, Remind participant of their ability to withdraw at any point and that they do not need to answer all questions
- Answer final questions from participant

Background Questions

- Age
- Gender
- Approximate time-frame for the start of depression
- Time period of depression
- Received counselling sessions

Experiences

- Can you tell me about your experience of depression?
- How did it begin?
- How would you describe the experience?
- What do you understand as the reasons for your depression?
- What support did you seek?
- What did you find helpful in terms of coping?
- In what ways do you understand your experience of depression in terms of your religion?

  Prompt: how does religion play a role in helping you understand your experience?
- Can you tell me about how your religion may have influenced the way you coped with depression?

  Prompt: Can you give me an example?
  How did this impact your experience of depression?
- What features of participation in religious services/practices, if any, were helpful for you?
- How did the way you understand depression (in terms of your religion) change the way you dealt with it?
- What resources do you consider religious, and were any of these helpful for you?
- Did you experience any negative effects of practicing religion on your depression?

Prompt: Can you give me an example?
What aspect of religion made it a negative effect for you?
In what ways did this change your experience of depression?

- How, if at all, has the practice of your religion changed as a result of the experience of depression?
- Can you tell me how the aspect of a Divinity, Allah, or the *Imam*, may have influenced the way you dealt with the depression?
- If another Ismaili was struggling with depression, what aspect(s) of religion would you recommend as helpful in coping with the depression?

Ending

- Overall what have you learnt from this experience of depression and your practice of your religion, that you will take forward with you?
- Is there anything else you would like to add?

Closure

- Review consent, provide debriefing: thank the participant, any questions/queries, contact details should they need to contact me, what happens next (feedback, data analysis, dissemination of findings).

Appendix F

ETHICS APPROVAL DOCUMENT

University Ethics Sub-Committee for Psychology

22/09/2015

Ethics Reference: 1020-am865-schoolofpsychology

TO:

Name of Researcher Applicant: Azmaira Mawji

Department: Psychology

Research Project Title: Religion and Depression: A Study of the Ismaili Community in Kenya

Dear Azmaira Mawji,

RE: Ethics review of Research Study application

The University Ethics Sub-Committee for Psychology has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:

No significant concerns have raised by the reviewers of the present application. Therefore, I am happy to approve it.

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

4. Reporting requirements after ethical approval

You are expected to notify the Sub-Committee about:

- Significant amendments to the project
- Serious breaches of the protocol
- Annual progress reports
- Notifying the end of the study

5. Use of application information

Details from your ethics application will be stored on the University Ethics Online System. With your permission, the Sub-Committee may wish to use parts of the application in an anonymised format for training or sharing best practice. Please let me know if you do not want the application details to be used in this manner.

Best wishes for the success of this research project.

Ethical Considerations During Research Process

Informed Consent

Potential participants were provided with information regarding the purpose of the study through a Participant Information Sheet and a Letter of Information. The same information from both documents was reviewed again on the day of the interview. Participants were assured that participation in the study was purely voluntary, and refusal to continue or withdraw was entirely their right. The researcher sought the participant's consent to tape record the entire session and participants were notified that authority to hear their recordings would lie with the researcher, the researcher's supervisor and the participants themselves. They were also assured that they could turn off the audio recorder at any point in time, that their personal information would be kept strictly confidential. An official University contact was given to each participant so that they could make an official report about any issues or concerns. Before meeting the researcher, potential participants were given enough time to make a decision about whether or not they wished to participate. Potential participants were also given the opportunity to ask any questions they had regarding their participation in the study. Subsequently, written consent to participate was sought.

Confidentiality

Participants were notified on the Letter of Information, the Participant Information Sheet and verbally by the researcher, that all information which had been gathered during the study would be kept confidential. Participants were also informed that the information gathered through the interview would only be used for the purpose of the research. Further,

that their names and other identifying information would not be used in any presentation or publication of the findings. The researcher also informed the participants that the data would not be used for future studies and therefore, seeking further ethical approval was not required.

Participants were advised that relevant, anonymised sections of the data would be looked at by Dr. Stephen Melluish, and that Dr. Melluish was the researcher's supervisor and would be involved in assessing and supervising the study. They were further informed that, in keeping with University requirements, all research data pertaining to the current investigation would be stored in a locked filing cabinet for seven years, after which time, it could be destroyed.

Potential Distress

This current investigation addressed a topic that was not seen to cause any form of distress or harm for the participants. The researcher nevertheless took several measures to address the issue of potential distress. First, prior to the interview, participants were informed that they could change their mind about participating in the study at any time, that they could also refuse to answer any question and withdraw from the study at any time, without providing a reason. Second, once the interview was finished, the researcher debriefed with participants and provided them with the space to talk about any negative impacts they may have experienced as a result of the interview. Third, the researcher gave her contact details to the participants in case they wished to talk about any issues brought up during the interview. The participants were also be given details of counselling centers available in the area. Finally, and most importantly, the respect for human dignity, privacy, inclusiveness, and free and informed consent was maintained at all times through the study.

Appendix G

Religious Coping and Depressive Symptoms: A Study of the Ismaili Community in Kenya
Information Poster

Religion and Depression among the Ismaili Community

Ismaili men and women aged between 18-65 years are invited to take part in a research study.

I am interested in interviewing you about your experience of depression and how your religion may have influenced the way you coped with it.

I am inviting Ismaili men and women who:

- Are fluent in reading and speaking English
- Have had a significant experience of depression in the past 6 months to 2 years
- Currently live in Nairobi

If you are interested in participating in this study or would like more information about it, please contact me on: amawji@olivetreepsych.com or 0733-455-559.

Thank-you,
Azmaira Mawji

Appendix H

Religious Coping and Depressive Symptoms: A Study of the Ismaili Community in Kenya
Letter of Information

My name is Azmaira Mawji. I am a doctoral student in the Applied Psychology program at the University of Leicester. Currently, I am researching religion and depressive symptoms among the Ismaili community and would like to invite you to take part in the study.

The purpose of the study is to explore how Ismaili adults living in Nairobi understand their experiences of depressive symptoms in terms of their religion, as well as how their religion may have influenced the way they coped with their symptoms.

If you agree to participate, I shall ask you a few questions about your experience of depressive symptoms and how your religion may have influenced the way you coped with them. When we have the interview, I would like to give you the chance to talk about any experiences you may have had in relation to this. The interview will last for approximately 60 minutes. I plan to audio record our interview, so that I can remember our discussion more easily. However, I will only use the audio recorder if you consent to it.

All information which has been gathered during the study will be kept confidential, and will only be used for the purpose of the research. Further, your names or other identifying information will not be used in any presentation or publication of the findings. The data will not be used for future studies and therefore, seeking further ethical approval will not be required. Relevant, anonymised sections of the data will be looked at by Dr. Stephen Melluish. Dr. Melluish is my supervisor and will be involved in assessing and supervising the study. The University requires that research data be stored for seven years, after which time, it can be destroyed. This study will keep to this requirement and all research data pertaining to the current study will be stored in a locked filing cabinet for seven years.

The risks of choosing to participate in this research study are minimal. However, if you do experience any form of distress, I will provide you with contacts and details of local resources which can help you.
Participation in this investigation is entirely voluntary. You can always change your mind about participating at any time through the study and this can be done without providing a reason. You also have the right to withdraw from the study or refuse to answer any question at any time. Again, you do not need to provide reasons for this.

If you would like, I can provide you with a copy of the findings of the study when it is completed.
If you have any questions about this study, please contact me on 0733-455-559 or you can email me on amawji@olivetreepsych.com.

This letter is your copy for future reference.

Thank you,

Azmaira Mawji

Appendix I

Religious Coping and Depressive Symptoms: A Study of the Ismaili Community in Kenya
Participant Information Sheet

Name of Researcher: Azmaira Mawji

I am inviting you to take part in my research study. This information sheet will help you to understand the purpose of the research and what would be involved of you if you decided to take part. If you would like, I can go through the information sheet together with you and would be happy to answer any questions you have about the study. You are welcome to talk to others about participating in this study and please feel free to ask me if there is anything you need clarification on.

What is the purpose of the study?
The purpose of the study is to investigate how adult members of the Ismaili community understand their experience of depressive symptoms in terms of their religion, as well as how their religion may have influenced the way they coped with their symptoms.

Why have I been invited?
If you experienced significant depressive symptoms in the past 6 months to 2 years, then you are invited to take part. The study will include a total of 6-8 participants like yourself.

Do I have to take part?
Taking part in the study is entirely optional and the decision lies with you. If you decide that you would like to participate, then you will receive this Participant Information Sheet to keep with you. I will also ask you to kindly sign a Consent to Participate Form before you begin the interview process with me. You always have the option to terminate your participation in the study at any time and without needing a reason. If you decide to terminate your participation, your decision will not affect your legal rights.

What will happen to me if I take part?
I will arrange an interview with you on a date, time and place that suits your convenience. During this interview, I will ask you some questions regarding your experience of depressive symptoms and how your religion may have influenced the way you coped with it. The total length of the interview will be around an hour, and after this interview, there will be no more meetings that you need to attend.

Expenses and payments
Participants will not be provided with any payment during the study. Only travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part?

This investigation will be addressing a topic that should not cause any form of distress or harm. However, if for any reason you do experience distress, several measures will be taken in an effort to overcome this. First, prior to the interview, you will be reminded that you can change your mind about participating in the study at any time, that you can refuse to answer any question, and that you can withdraw from the study at any time, without providing a reason. Second, once the interview is finished, I will debrief with you and provide you with the space to talk about any negative impacts you may be experiencing as a result of the interview. Third, I will give my contact details to you should you wish to talk about any issues brought up during the interview. You will also be given details of counselling centers available in the area. Finally, and most importantly, the respect for human dignity, privacy, inclusiveness, and free and informed consent will be maintained at all times throughout the study.

What are the possible benefits of taking part?

One potential benefit is that you might experience a positive feeling from being able to share your experiences, and having these experiences heard and affirmed. Additionally, I hope that the results from the current study can provide better insights into the relationship between religion and depression among the Ismaili community, which will in turn have implications for improved treatments for this problem. These improvements would extend to the entire community, including participants of the study.

What happens when the research study stops?

The results of the current study will be shared with the study participants as well as with the University of Leicester. The researcher plans to write-up the study and submit it as part of a doctoral thesis. This research will also be submitted for publication in a peer-reviewed journal.

What if there is a problem?

You are welcome to speak with me regarding any concerns or issues you might have. You can contact me on the details provided at the end of the Participant Information Sheet. However, if you feel dissatisfied and still have concerns about anything related to the study, you can make a formal report to the University of Leicester.

Will my taking part in the study be kept confidential?

I will give you a Letter of Information and this Participant Information Sheet, and I will also clarify with you verbally that all information which has been gathered during the study will be kept confidential. The information gathered through the interview will only be used for the purpose of the research. Further, that your name(s) or other identifying information will not be used in any presentation or publication of the findings. The data will not be used for future studies and therefore, seeking further ethical approval will not be required. Relevant, anonymised sections of the data will be looked at by Dr. Stephen Melluish. Dr. Melluish is my supervisor and will be involved in supervision of the study. The University requires that research data be stored for seven years, after which time, it can be destroyed. This study will keep to this requirement and all research data pertaining to the current investigation will be stored in a locked filing cabinet for seven years.

Your personal data, such as address and telephone number, will be stored for one month after the completion of the research investigation. This is so that I can contact you to share the findings of the study with you, unless you advise me that you do not wish to be contacted.

What will happen if I don't want to carry on with the study?
As mentioned earlier, you are free to decide whether you would like to take part in this study or not. Even if you do decide to take part, you can always change your mind and withdraw from participation at any time. You will not have to provide a reason for this decision and rest assured that your legal rights will not be affected. If you do decide that you would like to withdraw from participation in the study, then please be aware that the information collected thus far cannot be deleted. Therefore, this information might nevertheless be used in the study.

Involvement of the General Practitioner/Family doctor (GP)
Your General Practitioner/ Family Doctor will not need to be involved.

What will happen to the results of the research study?
I will compile, analyze and report the findings of the study. I plan to submit the entire study as partial fulfillment of the doctorate degree requirements, which I am enrolled in. This submission will take place in October 2016. Once I receive approval of the results, I can contact you within the next month so that you can get a copy of the results. I will only contact you if you would like me to. Your name or other identifying information will remain strictly confidential and will not be used in any report/publication of the results.

Who is organizing and funding the research?
I am organizing and funding my research. My supervisor, Dr. Melluish, is overseeing the process of my research.

Who has reviewed the study?
The University of Leicester Ethics Committee has reviewed this study and given it a favorable opinion.

Further information and contact details
Azmaira Mawji

Phone number: +254726370349

Email: amawji@olivetreepsych.com

Appendix J

Religious Coping and Depressive Symptoms: A Study of the Ismaili Community in Kenya
Consent to Participate Form

By signing this form, I agree that I have read and understood the Letter of Information and the Participant Information Sheet. I also agree that I have had the details of this study fully explained to me, and that I have had all my questions answered to my satisfaction. By signing this form, I further agree to voluntarily participate in this study, and understand that I can freely withdraw from the study at any point in time, without needing a reason.

Do you give me consent to audio record our interview? YES_____ NO _____
(kindly circle and then please write your initials)

Name (please print): _____

Signature: _____ Date: _____

Appendix K

Sample of Coding

Summary/Codes	Original Transcript	Exploratory Comments and Ideas
Free to express herself with God Khane: A place of safety and acceptance Khane as stability: this contributed to the recovery process	*"...and everyday was different, you know? So sometimes I would talk [to God in the Khane] about how bad things were, how good things were, sometimes I would ask for certain things, but like...what it created for me...I guess... was a place to go, without having to speak to anyone, but be able to release the things that were inside of me...and it just kind of gave me a stable ground to have, to just go and vent...and over time as things started to get better..." (Aliyana, 61-66)*	A sense of ease to talk about anything that came up, being able to be herself when conversing with God A place of solitude, safety, and possibly acceptance seemed important to be able to release pent up emotions and experiences A sense of stability and perhaps even consistency (?) of going to a single place, having the same opportunity to vent, and having the same result of feeling better
Positive impact of socializing with the community Provides an important sense of connection	*"...I started going to Khane again and interacting with people...and once I started that people in Khane would come to me and say where have you been? We've missed you! And so it was like, oh, people have been thinking about me, and then I would hear about stories from certain friends and they'd say so-and-so asked about you and what's going on? So, uh...that was alittle bit...of an eye opener, and it was like, ok so I'm not really alone in this, there are people that care..." (Sahir, 109-115)*	Surprised that people missed him and were happy to see him; that he matters to others and people even asked about him A sense that there is support, that people care, and this helps ease the loneliness

Appendix L

Extract from Researcher's Journal

Excerpt of reflections during the interview process with participants.

...I noticed myself enjoying the interview process more now and interacting more naturally with participants as I start to relax and engage with the interview. I also find that with this helps me to learn better from them and I can connect better with their experiences as they narrated them to me. I also find myself going through mixed emotions as I listen to them. For instance, when they talk about how heavy the depression was for them, I feel empathy, and when they talk about how angry they were at God, I feel surprised at how open they are to express this, and when they talk about how they overcame the depression, I feel happy for them. It may be that I am picking up on their own emotional experiences as they talk...and have to be cautious not to let this interfere when I analyze the data...

Part C: Service Evaluation

Title: Evaluating Professional Development within the Community Counselling Services (CCS): Exploring Counsellors' Perspectives

Executive Summary

Practicing psychologists are encouraged, and in several countries, required to participate in professional development programs (Jameson, Stadter, & Poulton, 2007). The American Psychological Association (APA) has outlined that professional development activities are needed to maintain and enhance professional competence, improve service delivery and outcomes, and to protect the public (Neimeyer, Taylor, & Cox, 2012). Although current research has largely indicated that professional development activities do improve psychological competence and professional practice, one limitation is that the larger portion of research looks at the degree of counsellor satisfaction with the program than the impact on clinical practice and client outcomes. A second limitation is that these studies focus only on psychologists practicing in Western countries. In regards to the national context, Kenya is in the process of establishing a single entity that regulates the standards of training that counselors receive (Okech & Kimemia, 2012). One local, community-based institution, the Community Counselling Services (CCS), organizes trainings which contribute to the professional development of its counsellors. However, there is no study that explores the extent to which these trainings improve counsellor's clinical practice and client outcomes. Thus, the objective of the current study was to explore CCS counsellors' perspectives of the professional development trainings within the CCS service and the extent that these trainings improve their therapeutic practice and skills.

Participants completed a questionnaire that explored their satisfaction with the learning experience, development of new knowledge, attitudes and skills, and the impact of the trainings on their client outcomes and service delivery. The researcher used template analysis to analyze the data, and five themes emerged. The overall findings indicated that while the counsellors experienced a broader scope of knowledge as well as positive client outcomes and service delivery when they were able to apply the information learned from the trainings, the practical components were insufficient and trainings were often too theoretically-orientated. This impacted their overall perception of the trainings and more importantly, their ability to fully translate the theory into practice. These findings, together with recommendations for improvement were reported with consideration of the existing literature, and a critical appraisal of the study was included. The findings will be formally fed back to the CCS accordingly.

1. Introduction

1.1 The Role of Professional Development in Counseling

Several researchers have noted that professional development, when provided formally, is easily recognizable, but rather difficult to define. According to Collin et al. (2012), the common denominator is that professional development concerns practices aimed at employees' development beyond that derived from their initial training. It is the means by which people maintain the knowledge and skills related to their professional lives (Collin et al., 2012). Practicing psychologists are encouraged, and required in several countries, to participate in professional development programs approved by their state organizations and licensing boards. According to APA, professional development activities are designed to maintain and enhance professional competence, to improve professional service delivery and outcomes, and to protect the public (Neimeyer et al., 2012). For psychologists, professional development activities include becoming board-certified, attending conferences, viewing webcasts, completing graduate classes, participating in formal continuing education programs, teaching classes or workshops, reviewing manuscripts, serving on professional boards, and a wide variety of self-directed forms of learning, such as reading professional books or journals and listening to professional recordings (Taylor & Neimeyer, 2015). These ultimately provide opportunities for psychologists to engage in new learning and to keep pace with the increasingly rapid changes in their fields (Neimeyer et al., 2012).

Research has largely indicated that professional development activities do improve psychological competence and professional practice. For example, Jameson et al. (2007) evaluated the effect of a 2-year continuing education program on therapy and on therapists themselves, among 38 therapists. The results indicated that following the program, positive changes were experienced in the therapeutic alliance quality, in the ability to work effectively with challenging clients, and in their own self-awareness. In other research, Neimeyer, Taylor, and Wear (2009), reported that approximately 80% of participants of professional development activities gave favorable opinions of the the programs they had completed, and 64% reported high or very high levels of learning from their these experiences. Further, Sharkin and Plageman (2003) found that a substantial percentage of participants perceived that their continuing education made them more effective clinicians.

The translation of new knowledge into actual practice has been the subject of some attention, as well. In their survey of over 1,000 psychologists, Neimeyer, Taylor, and Philip (2010) found that a substantial percent (63%) reported that their formal continuing education experiences translated into their practices frequently or very frequently. However, in a more recent study of more than 1,600 licensed psychologists, Neimeyer et al. (2012) found wide variability in the extent to which psychologists themselves perceived their various continuing professional development activities as contributing to their ongoing professional competence or the protection of the public. One limitation with these findings is that the studies largely tend to look at the degree of counsellor satisfaction with professional development than the impact of the program on the clinical practice and client outcomes. A second limitation is that these studies focus only on psychologists practicing in Western countries.

1.2 Evaluating CPD

Evaluation of professional development is usually an immediate assessment of participants' degree of satisfaction that the workshop met its stated goals, most of which are content related. However, less research looks at the impact of this type of development on the participants' understanding of the content or on how they use it (Jameson et al., 2007). According to (Neimeyer et al., 2010), the greatest concerns about levels of continuing education participation would follow from direct evidence regarding its effectiveness in relation to generating favorable outcomes. Unfortunately, the current literature available does not provide clear-cut evidence in this regard. This is largely due to challenges in evaluation and the limited number of studies in this area (Neimeyer et al., 2010).

There are several difficulties in conducting accurate and thorough evaluation. One, participants frequently come from different settings and with differing learning needs that are challenging to integrate together into learning objectives and comprehensive evaluations. Two, the interdependence of health professionals makes it a difficult talk to connect the education of a particular professional with their client outcomes. Three, it is difficult to discern when the material from an educational intervention will eventually impact professional conduct. Four, even if these learner variables are dealt with, there are still challenges regarding the lack of agreement of an appropriate, valid and reliable measure for evaluating client outcomes (Williams, 2007). Dixon's (1978) learning

taxonomy for professional development, listed below, outlines four levels of evaluation that are necessary to obtain a comprehensive evaluation of training outcomes.

1. Perception/Opinion: satisfaction with the learning experience and the learner's perceived progress.
2. Competency: demonstrated new knowledge and attitudes.
3. Performance: demonstrated new skills.
4. Outcomes: demonstrated impact on client outcomes and service delivery.

According to Neimeyer et al. (2010), research in the area of evaluating continuing professional development can generally be classified into a series of four categories, each marked by its distinctive measures. These categories closely align with Dixon's four levels of evaluation and include studies that assess the extent of participants' a) overall satisfaction, b) levels of new learning, c) translation of knowledge into practice, and d), the impact of that translation on the effectiveness of services that are delivered.

1.3 National Context

The counseling profession in Kenya is largely in its formative years. Although the 'talking cure' is a practice Kenyans are long familiar with, the contemporary Western concept of a counselor is new and one that the wider Kenyan community is slowly beginning to embrace. Currently, there is only one national licensure body that recently came into being, and attempts to establish a single entity that regulates the standards of training that counselors receive is still in process (Okech & Kimemia, 2012). Currently in the country, there are three major organizations for counsellors namely, the Kenya Association of Professional Counsellors (KAPC), the Kenya Psychological Association (KPsyA), and the Kenya Counselling Association (KCA). All three include in their objectives an aim to improve counsellor practice through professional development. Although the 2014 Kenyan Counsellors and Psychological Act outlines as one of the functions of The Counsellors and Psychologists Board to "collaborate with training institutions, professional associations, professional organizations and other relevant bodies in matters relating to training and professional development of counsellors and psychologists" (Republic of Kenya, 2014, p.174), the existence of several, competing organizations leads to several difficulties in developing common standards of training, professional development activities regulation and supervision (Okech & Kimemia, 2012).

In addition to this, there is currently no known literature that examines the extent to which professional development for psychologists in Kenya impacts their therapeutic practice and skills.

1.4 Local Context

1.4.1 The Community Counselling Services (CCS)

CCS was initiated by The Aga Khan Social Welfare Board of Kenya in 1990 order to address mental health problems within the Ismaili community. It was designed to create a climate of awareness, confidentiality and be a source of support and empowerment for the community during problem situations. The CCS main objectives are to provide counselling to the Nairobi Ismaili community on a voluntary basis, to create a level of awareness of mental health within the community, and to contribute to the professional development of the CCS counsellors. The interventions used by CCS are preventative, supportive or therapeutic according to the nature of the problem being dealt with. CCS achieves these objectives through the establishment of eight modules, or sub-committees within the service, which addresses relevant and existing issues in the community. These modules are Youth Counselling, Geriatric Counselling, Physically and Mentally Challenged, Bereavement and Medical Counselling, HIV and AIDS, Marital and Pre-Marital Counselling, Alcohol and Drug Abuse, and Parenting. CCS further has monthly meetings where issues pertinent to the service are discussed and also holds supervision sessions on a monthly basis where counsellors can discuss and receive input on their cases. It is currently manned by 11 counsellors, of which nine are professionally qualified, in that they have or are at least engaged in a master's degree in counselling or clinical psychology, and two are lay counsellors, which means they have at least a certificate in basic counselling skills. Further, eight cousellors are Ismaili and three are non-Ismaili (CCS, 2015).

1.4.2 Professional development

As noted above, one objective of the CCS is to contribute to the professional development of its counsellors, with the purpose of "improving their skills" (CCS, 1997, p.5). This objective has been active since the inception of CCS but in 2006, a more structured approach was taken to professional development where 4 in-house trainings and 2 external trainings were proposed to be conducted annually as part of professional development. The proposal was accepted and these trainings have continued to the present

day. The in-house trainings are open only to CCS counsellors and are conducted by a CCS professional counsellor. The external trainings are also only open to CCS counsellors but are conducted by a non-CCS professional counsellor or other mental health-related organization. All six training sessions are mandatory for the CCS counsellors to attend. Previous topics of training and presentation have included grief, depression, post-traumatic stress disorder, self-care and burnout, Acceptance and Commitment Therapy (ACT), Psychological First Aid (PFA), Skills for Psychological Recovery (SPF), Emotional Freedom Technique (EFT), among others (CCS, 2015).

1.5 Purpose of the Study

Within the Ismaili community, however, there is no known research that explores the extent to which the CCS professional development trainings improve counsellor's therapeutic skills. Given that the number of professional counsellors within the Ismaili community is increasing rapidly, and that CCS is expanding and becoming a more professional service, it was deemed vital to evaluate professional development within this service. Thus, the objective of the current study was to explore CCS counsellors' perspectives of the professional development trainings within CCS and the extent that they impact counsellors' therapeutic practice and skills.

2. Method

2.1 Participants

The sample for the current study comprised of six CCS professional counselling psychologists. Five were female and one was male. Their ages ranged from 28-48 years old and they had all completed at least three years with CCS. Counsellors were eligible to participate if they had attended all six professional development trainings over the span of the previous year. The reason for the time frame of the previous year was for ease of recollecting their experiences of attending the trainings. Additionally, the reason for selecting the eligibility criteria of attending all six trainings was so that participants would have had full exposure to the trainings and therefore be able to provide more detailed accounts of their experiences. Further details of the participants are given in Table 1 below.

Table 1: Summary of Participant Information[3]

Name	Gender	Age	Number of Years Completed with CCS	Qualification
Sheila	F	29	4	M.A. Counselling Psychologist
Fatima	F	28	7	M.A. Counselling Psychologist
Begum	F	48	4	M.A. Counselling Psychologist
Neera	F	36	3	M.A. Counselling Psychologist
Khatun	F	39	6	M.A. Counselling Psychologist
Zul	M	41	5	M.A. Counselling Psychologist

2.2 Methodology

In the current study, a qualitative approach was used since quantitative methods would draw out insufficient information about CCS counsellors' experiences of the professional development trainings, making it challenging to create future recommendations. Further, current literature outlines certain areas that can be explored when evaluating continuing professional development, and CCS outlines its own objective of professional development.

[3] Pseudo-names have been used to protect participant confidentiality.

Given this, as well as the interest in eliciting experiences from the CCS counsellors, Template Analysis (TA) was deemed a suitable approach. TA is a method of analysis that allows data to be thematically coded for analysis and can be used from a range of epistemological positions (King, 1998).

2.3 Procedure

During the CCS monthly meeting, where all counsellors were present, the researcher explained the purpose and the method of the study to be undertaken and asked if counsellors would be willing to participate. The first six members who agreed to participate were asked to sign a Consent to Participate Form (Appendix A) before being given The Professional Development Questionnaire (Appendix B), a semi-structured questionnaire, to complete. Prior to giving the questionnaire, the researcher requested participants to answer each question as thoroughly as possible and with as much detail as possible. This request was also noted on the questionnaire itself. At the same time, the researcher asked participants if, once the completed questionnaire was received by the researcher and the researcher needed clarification or further explanation for a particular response, the researcher could follow up with a phone call to the relevant participant. While all participants consented to this, a follow-up phone call was not needed as all participant responses were provided with sufficient explanation and detail.

2.4 Measures

As noted above, participants were given The Professional Development Questionnaire which included questions regarding their experiences of attending the CCS professional development trainings and to what extent the trainings impacted their therapeutic practice and skills. The questions were topic-focused, but also open-ended enough to allow flexibility for including notes on any additional areas.

The questionnaire reflected the following areas, which are closely aligned with Dixon's (1978) four levels of evaluating continued professional development:

1. Satisfaction with the learning experience
2. Competency through new knowledge and attitudes
3. Translation of knowledge into practice through improvement of therapeutic skills
4. Impact on client outcomes and service delivery.

2.5 Analysis

In the interview schedule, four a priori themes were identified. According to King (2009), certain topics are likely to arise by the nature of the questions asked and therefore a priori themes are identified. This framework was applied to the first questionnaire, where the researcher coded specific parts of the data which corresponded with the a priori themes. This was done to help identify these parts at a later stage. Further, when new topics emerged, new themes were subsequently created, thereby expanding the framework. This process was done with the first three questionnaires, creating an initial template. This involved grouping together some existing themes into larger, higher-order themes, with smaller, specific themes 'beneath' them. This initial template was then applied to the remaining questionnaires, with any new themes being added or existing ones modified as necessary. The final template (Appendix C) was used during the analysis and interpretation of the results.

3. Results

3.1 Perceptions of the learning experience: *"Getting Lost in Theory"*

When describing their perceptions of the learning experience, a theme that prominently ran across participants' reports was that of the trainings being too theoretically-orientated. Participants reported that while the topics presented were relevant to the cases they were commonly handling, the trainings largely covered the theoretical aspect of the topic. Some found this to interfere with their learning objectives and one participant described the experience as *'getting lost in theory'.* Participants 6 and 1 capture these points as shown in their quotes below.

> *"Perhaps the main concern is too much time spent on explaining how this therapy came about, why it was developed, what does it treat, etc, focusing on the background behind the therapy." Participant 6*
>
> *"Topics are very interesting and they help a lot with my current cases...too much lecture...you find yourself getting lost in theory. This can be disappointing because you come to the trainings to learn how to use it" Participant 1*

Participants also reported that although most speakers were highly qualified in their fields of training, they commonly resorted to one of the easiest methods of delivery, which is lecturing. However, for participants, this was experienced as boring and lacking stimulation. They further noted that making trainings more interactive and using diverse teaching styles would help keep sessions lively and even speed up the rate of learning that takes place.

> *"I'd appreciate approaches like multi-media presentations - keeps me glued - powerpoint presentations and interactive sessions would be great - trainers and [CCS] counsellors are so knowledgeable and lecturing is boring and doesn't do it justice." Participant 4*

3.2 A Broader Scope of Knowledge

A second theme that emerged among the majority of the participants was experiencing an overall broadening of their knowledge base as a result of the trainings. Specifically, participants noted that the trainings helped them develop a greater understanding of clinical issues and how these are experienced in a therapeutic setting. For instance, Participant 3 appreciated the variety of topics presented and found this particularly helpful in broadening her scope of clinical knowledge.

"Different topics every time add a little more to your hard-drive and it comes in handy when you're with a client, because you don't learn all this in your Master's...it [trainings] makes you that much more competent because your clinical knowledge is expanded." Participant 3

Several participants also experienced knowledge through shared learning that took place during the training sessions. Specifically, participants reported not only learning from the trainer, but also from each other when opinions, experiences and information were openly shared in the group. For Participant 5, this was experienced during Q&A as is seen in her quote below.

"...but also I learn through listening to others during Q&A." Participant 5

Participant 2 also expressed this point very clearly when she discussed the benefit of open discussions.

"...the interactions are so good to learn from, eg. during the [name of] training, so much open discussion happened about gays and lesbians and it was really informative for me." Participant 2

Interestingly, some participants noted that not only did their clinical knowledge increase as a result of the trainings, but areas of personal development were also impacted. For example, Participant 3 reported that, as a result of the trainings, she experienced increased self-awareness during her sessions with clients, where she became more aware of their reactions and judgments.

"Afterwards [after the trainings] I was careful about my judgments and reactions in the session...how I felt about what was being discussed and what it brought up for me in my body and in relation to my own life." Participant 3

Participant 6 noted that the trainings helped him to experience a change in his attitude towards himself and an awareness of his own limitations as a counsellor.

"Knowledge and attitude about myself changed...I know about my limitations as a counsellor, my personal strengths and weaknesses, and how even I am an evolving project!" Participant 6

3.3 Bridging the Gap between Theory and Practice: The Need for More Practical-based Trainings

Participants expressed that while they were able to apply varying degrees of what they learned in the trainings to their practice, there was a need for greater incorporation of practical components into the trainings to facilitate the application of skills. Many reported that it was during the practical parts of the training that tremendous learning took place, as that was when they were able to translate theoretical knowledge into specific skill development. Participants felt this would not only make learning experiential but also give them a sense of confidence when trying out new techniques in their practice. Participant 4 describes this point in her extract below.

> *"...need more practice - need videos clips, case simulations, demo's, so we see them [skills being taught] in action - that is learning otherwise it becomes hard to take it [teachings] away with you." Participant 4*

Another important suggestion that came up in the data was the need for follow-up and support. Specifically, participants felt that attending single training sessions to learn a new technique was insufficient to prepare them to use it in sessions. Participant 6 captured this point aptly.

> *"...would be tremendously helpful and important, I think, to have follow-up sessions with the speaker where we have a platform to discuss the progress of applying the skills in our practice...one at a later date or several sprinkled over the weeks, depending on the therapy we learnt." Participant 6*

In her report, Participant 3 noted the need for continued supervision for guidance purposes.

> *"...with trainings like play therapy, for eg., 8 hours is hardly enough...continued case supervision during the meetings would be good...it really helps to be guided as you're learning to use it." Participant 3*

3.4 Client outcomes and Service Delivery

Regarding client outcomes and service delivery, participants reported that when they were able to apply what they learned in the trainings to their practice, they observed positive results for both. Regarding service delivery, participants reported being more knowledgeable about new therapies, more aware of client experiences, and developing improved clinical decision-making skills. They also noticed that they were able to broaden their own client base with the new knowledge they gained. Participants 6 and 2 capture this point in their quotes below.

"I am more educated about best practices in therapy and I can connect with my clients experiences better. With that education I can more effectively serve...I listen better and can pick up insights faster, with a larger set of empirically-based techniques I can integrate more which is so powerful because it's so effective." Participant 6

"Now I make better decisions about what therapy to use...about the sessions, and when to refer, about report writing and supervision." Participant 2

In regards to client outcomes, participants reported observing a quicker recovery process with their clients and one participant, Participant 6, noted that his clients were able to meet their goals more meaningfully.

"They [clients] are able to achieve their goals more meaningfully...its not necessarily about speedy recovery, but about helping the client to experience meaningful and progressive change in a way that they [the client] are satisfied with." Participant 6

Participant 3 noted an improved therapeutic relationship where her clients felt more understood and more effectively assisted.

"...therapeutic relationships with my clients became stronger and with more empathy because I had become a better counsellor." Participant 3

3.5 "Sensitivities of the Local Context"

The fifth theme that emerged from the data involved sensitivity to the local context. Specifically, participants noted that most trainings were conducted on techniques and psychological theories developed in the West, and applying these to the local, Ismaili context proved challenging in some cases. Participants expressed a need for the trainings to be geared more to the local context, where clinical issues that related specifically to the community could be discussed in relation to the material being taught. Three points emerged in the data as areas of sensitivity for the Ismaili community when dealing with mental health issues. First, that Ismailis are more communal than independent, second that religion and spirituality may influence mental health and well-being for an Ismaili, and third that there exists a taboo among members of the community to seek mental health services. The quotes below capture these points.

"When they [therapies] are tailored to that [local] situation, it becomes most applicable. In several trainings I have noted that aspects like 'women's shelter' or 'independence from the family' or 'accepting responsibility for your problem' are

sometimes difficult to apply because Kenyans and Ismailis are so community orientated, and we have no such thing as women's shelter...some [Ismaili clients] believe it is Allah's will, so what do you do with that?" Participant 6

"...many Ismailis still hesitate to come to CCS for help, and that aspect hasn't really been addressed in the trainings...people are still very skeptical about it...the approach you take in counselling has to be sensitive to this." Participant 1

"...we have to also realize that these people [Nairobi Ismailis] have family and community, cultural and social and religious dynamics that are different from Westerners, so the client base we are dealing with here is different from America or Australia...the trainers don't always pay attention to that in their lectures, but it would be good if we could discuss that more often, so that we are suiting the trainings to the mental health needs and sensitivities of the local context." Participant 3

4. Discussion

An analysis of the results revealed that overall, while CCS counsellors experienced a broader scope of knowledge as well as positive client outcomes and service delivery when they were able to apply the information learned from the trainings, the practical components were insufficient and trainings were often too theoretically-orientated. This impacted counsellors' overall perception of the trainings and more importantly, their ability to translate the theory into practice. Discussion points regarding these findings as well as clinical implications and limitations of the current study are discussed below.

The findings summarized above are supported by several strengths in the study. First, all participants were professional counsellors and therefore, could comment on areas such as changes to service delivery, client outcomes and clinical knowledge. Second, as the researcher was also a CCS counsellor, this likely made it easier for participants to describe their experiences in relation to various trainings in CCS without needing too much explanation as the researcher would already understand the context. Additionally, being a member of the same religion as most of the participants likely made it easier for participants to report any issues related to religion. Third, the researcher took several steps to try and ensure the quality of the study, as outlined by Braun and Clarke (2006). For example, the researcher discussed preliminary themes with the supervisor and a fellow doctorate student as a quality check. Additionally, through reflexivity, the researcher also acknowledged that the way she made sense of and interpreted the data may have been influenced by her own beliefs, as well as how the data itself may have influenced her. Further, the researcher ensured that the sample was appropriate for the study by interviewing a highly homogeneous group.

Despite these strengths, however, there were also several limitations and methodological issues which must be taken into account. For example, the researcher selected the first six participants who volunteered to be a part of this study. This method of recruitment may have resulted in a biased sample of more outspoken counsellors. Secondly, completing a questionnaire may not draw out as rich information as a personal interview would. Third, being a member of CCS and of the same religion may have limited participants in expressing negative beliefs, opinions and views about CCS or about the religion for fear of negative judgment by the researcher. Fourth, no lay counsellors

volunteered to be part of the study, which resulted in an exclusion of their thoughts, opinions and experiences of professional development in CCS. One can speculate that since lay counsellors do not possess the required qualifications in counselling to practice independently, perhaps they are not able to fully understand the contents of the trainings, and therefore, opted not to volunteer as a participant of the current study. Nevertheless, since they are CCS members, it may be important to conduct future evaluations on their experiences of professional development and how they make use of the knowledge they gain in the trainings.

A second point of discussion is in regards to the practical components of the trainings. All participants reported that insufficient practical training resulted in a challenge to translate theory to skill development. Although they experienced certain benefits of theoretical knowledge, such as a greater clinical knowledge, increased self awareness, and increased effectiveness as a counsellor, which is consistent with previous research (Jameson et al., 2007; Neimeyer et al., 2009; Neimeyer et al., 2010; Sharkin & Plageman, 2003), there was a clear opinion that the trainings needed to include greater practical components. It appeared that participants considered this a central aspect of professional development and in ensuring effective application of skills. These comments are also consistent with other research which notes that learning is advanced through educational interventions that simulate circumstances and situations applicable to the professional role (Williams, 2007). Neimeyer et al. (2010) also note the importance of a shift from didactic approaches of teaching to learning activities that are defined by practical applicability, such as modeling and role-playing. The participants of the current study also noted the need for continued support and supervision to ensure correct learning and application of the skill or therapy taught. This appeared to be another important aspect of the participants' professional development where the need for guidance and support would likely crystallize the learning into effective practice.

The third point of discussion is that the CCS structure of professional development excludes any informal professional development activity. However, according to Taylor and Neimeyer (2015) professional development activities also include viewing webinars, completing graduate programs or classes, attending conferences, reviewing manuscripts, serving on professional boards, and self-directed learning such as reading professional

books or journals and listening to professional recordings. It is possible that CCS kept the focus of professional development only on formal trainings as trainers are generally easily available and formal trainings are the most familiar forms of continuing education for the CCS counsellors. Further, the lack of professional boards, local webinars, research opportunities and professional conferences in the country may also have made it difficult for CCS to include such activities in their professional development structure. However, with the recent establishment of psychological organizations, such as the KPsyA, and with the availability of information on clinical issues and research on the internet, it may be beneficial for CCS to consider broadening their structure of professional development to incorporate these additional activities. This would not only provide opportunities for self-initiated learning, but also add variety to counsellors' learning experiences.

4.1 Clinical Implications

The findings of the current study offer helpful suggestions to improve the CCS professional development structure to make better use of it in clinical practice. The main recommendations that will be suggested to CCS are noted below.

1) It is advised that trainers diversify their presentation styles and include methods such as multi-media presentations or small groups, which would and make sessions more interactive and stimulating.

2) It is recommended that trainings include more practical components to help translate theoretical knowledge into skill development. Examples of these components include simulations, case examples, video-clips and demonstrations.

3) It would be beneficial for CCS to organize follow-up sessions with the trainer where members can get an opportunity to discuss the progress of applying the training material in their practice and receive guidance on this process. This support might also take place in the form of peer-support during the monthly CCS meetings.

4) It is recommended that during trainings, speakers sensitize training material to the local Ismaili context, with particular attention being paid to three areas including a sense of communal, rather than independent, living among Ismailis, an existing taboo to seek mental health services, and the influence of religion on the mental health and well-being of an Ismaili.

5）It may be beneficial for CCS to include informal professional development activities to provide variety to counsellors' learning experiences and opportunities for self-learning.

4.2 Dissemination process

The researcher has informally fed back the findings of the current study to the convener of CCS. The convener responded with appreciation and a readiness to begin planning the implementation of the recommendations. CCS will also be sent a copy of the findings and the research is currently organizing to formally present the results to the members.

5. Critical Appraisal

The main strength of the study was the qualitative approach that was taken, which allowed for the exploration of CCS counsellor's experiences of the professional development trainings. Template analysis was also useful as it enabled the research aim to be included in a template for interviewing. However, a possible weakness of this method was the large volume of data to be analyzed in a restricted time, which may have led the analysis to be less in-depth as would have been ideal. Through a reflection of the current study, the researcher became aware of some effects the study had on her. For example, the researcher found it interesting that through professional development trainings, one not only learns about new therapies and skills, but can also learn about themselves both personally and professionally. Self-awareness of one's personal strengths and weaknesses, one's limitations as a person and a counsellor, and the importance of self-care are some examples of this that came up in the current study. The researcher was also struck by participants' awareness of how these insights impacted their clinical practice, and subsequently, client outcomes.

The researcher also learned about the power of shared learning that takes place during trainings. It was insightful for the researcher to become aware that for some participants, their greatest learning experiences took place when thoughts and opinions were shared by other counsellors in the training. Third, the researcher learned about the CCS professional development trainings strengths and weaknesses. The current study findings outlined which aspects were beneficial for the counsellors and which needed improvement. The findings also indicted how both aspects had implications for effective skill development and application, service delivery and client outcomes. The researcher also experienced a

renewed value and appreciation for the importance of professional development for all counsellors.

The researcher reflected on how she may have impacted the findings. For example, being a member of CCS and being an Ismaili may have made it easier for participants to explain certain concepts relating to CCS or the religion. However, on the flip side, this may have hindered them from expressing negative beliefs or opinions about the trainings for fear of being judged by the researcher. Additionally, being aware that the results would be fed back to CCS may have also prevented them from being fully honest about their experiences and opinions. Acknowledging this, the researcher is acutely aware that the findings and recommendations of the current study will have to be fed-back to CCS with sensitivity and respect, so as not to suggest blame to any aspect of the service, or foster a sense of hopelessness with the recommendations. It is encouraging to know, however, that thus far, CCS has responded positively to the informal feed-back of the findings and have expressed eagerness to implement the recommended changes.

References

Collin, K., Van der Heijden, B., & Lewis, P. (2012). Continuing professional development. *International Journal of Training and Development, 16*(3), 155-163.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Community Counselling Services. (1997). *Guide to Community Counselling Services (CCS)*. Nairobi: Aga Khan Social Welfare Board.

Community Counselling Services. (2015). *CCS Statistics*. Retrieved from CCS Statistics Database.

Damji, T., & Lee, C. (1995). Gender role identity and perceptions of Ismaili Muslim men and women. *The Journal of Social Psychology*, *135*(2), 215-223.

Dixon, J. (1978) Evaluation criteria in studies of continuing education in the health professions: A critical review and a suggested strategy. *Evaluation and the Health Professions, 1*(2), 47–65.

Jameson, P., Stadter, M., & Poulton, J. (2007). Sustained and sustaining continuing education for therapists. *Psychotherapy: Theory, Research, Practice, Training, 44*(1), 110-114.

Neimeyer, G., Taylor, J., & Cox, D. (2012). On hope and possibility: Does continuing professional development contribute to ongoing professional competence? *Professional Psychology: Research and Practice, 43*(5), 476-486.

Neimeyer, G., Taylor, J., & Philip, D. (2010). Continuing education in psychology: Patterns of participation and perceived outcomes among mandated and non-mandated psychologists. *Professional Psychology: Research and Practice, 41*(5), 435-441.

Neimeyer, G., Taylor, J., & Wear, D. (2009). Continuing education in psychology: Outcomes, evaluations, and mandates. *Professional Psychology: Research and Practice, 40*(6), 617-624.

Okech, J., & Kimemia, M. (2012). Professional counseling in Kenya: History, current status, and future trends. J*ournal of Counseling & Development, 90*(1), 107-112.

Republic of Kenya: National Council for Law Reporting. (2014). *The Counsellors and Psychologists Act* (Publication No. 14). Retrieved from

http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/Counsellors%20and%20PsychologistsActNo14of2014.pdf

Sharkin, B., & Plageman, P. (2003). What do psychologists think about mandatory continuing education? A survey of Pennsylvania psychologists. *Professional Psychology: Research and Practice, 34*(3), 318-323.

Taylor, J., & Neimeyer, G. (2015). Public perceptions of psychologists' professional development activities: The good, the bad, and the ugly. *Professional Psychology: Research and Practice, 46*(2), 140-146.

Williams, C. (2007). Mixed-method evaluation of continuing professional development: Applications in cultural competence training. *Social Work Education, 26*(2), 121-135.

-

-

-

-

-

-

-

-

-

-

Appendix A

Evaluating Professional Development within the CCS

Consent to Participate Form

By signing this form, I agree that I have been informed of and understand the purpose and nature of this study. I also agree that I have had all details of this study fully explained to me, and that I have had all my questions answered to my satisfaction. By signing this form, I further agree to voluntarily participate in this study, and understand that I can freely withdraw from the study at any point in time, without needing a reason.

Name (please print): _____

Signature: _____ Date: _____

-

-

-

-

-

-

-

Appendix B

- **The Professional Development Questionnaire**

How well did the content of the training support your learning objectives?

How were the trainings relevant to your practice as a counselor?

What approaches were used in the trainings? How helpful were these approaches for your learning?

What changes in your clinical knowledge and attitudes have you noticed as a result of the trainings?

In what ways have you been able to apply what you learned in the trainings in your practice, if at all?

Has your skill level changed as a result of the training activities? If so, in what ways?

Do you feel that the trainings have helped you become a more effective counsellor? If so, in what ways?

How have the trainings impacted your client outcomes?

In your view, what aspects of the trainings are helpful?

In your view, what aspects of the trainings are unhelpful?

How could it be improved?

Appendix C

Final Template

Super-ordinate Themes	Subordinate Themes
Perceptions of the Learning Experience: *"Getting Lost in Theory"*	Relevancy, but too much theory
	The need to diversify methods of delivery
A Broader Scope of Knowledge	Greater understanding of clinical issues
	Shared learning
	Personal development
Bridging the Gap between Theory and Practice: The Need for More Practical-based Trainings	Greater incorporation of practical components
	The Need for Follow-up and Support
Client Outcomes and Service Delivery	Using best practices
	Improved client outcomes
"Sensitivities of the Local Context"	Communal versus independent functioning
	Counselling is a taboo
	Religion and the process of healing

Part D: Critical Reflection

A reflective journal written throughout the research process forms the basis of the discussion below.

1. Development of the Research Topic

My interest in conducting research among the Ismaili community grew from my own personal and religious connection with it. Being an Ismaili and having been brought up within the religious culture, I desired to use that bond to help me better understand mental health among the community members and how to help those who experience mental health problems. Having volunteered with the Community Counselling Services (CCS) for the past 7 years, I became aware of the various mental health issues that were being experienced in the community. I also began to realize that depression was a problem many adults reported experiencing and upon inquiring into the CCS statistics of depression cases over the past five years, I was struck to find out that the number of reported cases had increased by over 900%. This figure also saddened me and I was moved to investigate this and produce research that would help alleviate this problem. Upon conducting a preliminary literature search on depression in the Ismaili community, I found only one study, which was not applicable to adult Ismailis living in a third world country. I therefore felt it important to carry out a study that could help add literature to this understudied field of research.

My interest in studying religious coping grew from my own connection with Ismailism. This connection dates back generations, where my great grandfathers worked closely with the Aga Khan I, and both male and female family members of mine were heavily involved in lifetime community service. As a child, my parents brought me up under the religious, social and cultural influence of Ismailism, forming my unique identity as a Shia Ismaili Muslim living in a third world country. Thus, I became curious to know what influence religion would have on an Ismaili's mental health. I therefore researched articles on religious coping and found a significant number of articles on this topic, with several focusing on different religious beliefs. However, as expected, there were no articles specifically examining religious coping in Ismailism. I therefore decided to combine my research interests and person connection with the Ismaili community to explore religious coping among Ismaili adults who experienced depressive symptoms.

2. Methodological Considerations

The recruitment method seemed appropriate for the study and the resulting sample fit the research aims. Placing a poster on the notice board of the main *Jamat Khana (*Ismaili house of prayer) in Nairobi inviting individuals to participate was determined to be the most effective way to access the largest gathering of Ismailis at a single time. However, one limitation with the recruitment method was that a poster cannot capture the attention of every single Ismaili adult. Thus, there may have been some Ismaili adults, who fit the inclusion criteria, but did not attend the *Jamat Khana* during the period the poster was on the notice board, or who had recovered from depression but were still avoiding the *Jamat Khana*. I took these limitations into account when planning the study and therefore inquired about sending a mass email to the Ismaili community about the study. However, I was informed that the community council did not have an updated list of every adult Ismaili's email address, and therefore some Ismailis may still be missed out. A second limitation with the recruitment method was that it relied on voluntary participation. This type of recruitment may give rise to participant bias, indicating that the data I have obtained may be biased towards particular individual characteristics (Smith, Flowers, & Larkin, 2009). Although this limitation was also considered during the planning phase, given the ethical considerations of confidentiality and consent, the current recruitment method was seen as the most practical approach to accessing adult Ismailis in Nairobi.

When I reflected on the decision to conduct interviews and use the IPA approach, I feel it was an appropriate one. I feel the semi-structured interview method not only fit with the IPA approach, but both fit with the qualitative nature and research aims of the current study. I also noticed that my interviewing technique gradually improved and became more natural over the course of the six interviews, where I was referring less to my topic guide while still being able to guide the discussion in a way that was relevant to the participants and the research topic. I also became aware that my anxiety about collecting the data I needed reduced and I focused more on openly listening to the participants and obtaining information that was important to them and significant to their experiences.

Over the course of the interviews, I also became comfortable knowing that the topic of discussion may tailor of focus and veer into related topics such as other personal problems.

While initially I was aware that participants were tailoring off, as I engaged more with the research process, I began to accept this as part of the research process and of the participants' experiences of depressive symptoms and religious coping. Conducting the interviews with this attitude made me enjoy them much more and I was able to learn more openly from my participants. My initial anxiety in using the IPA approach was also evident to me in the early stages of the research. When I first read about it, I found it daunting and complicated, and wondered how I would make sense of the volume of data using this approach. However, as I read more into it, I began to understand it better and slowly was able to analyze the data into meaningful themes that reflected participants' accounts. I wonder if it might have been helpful to conduct a pilot interview and analysis prior to conducting the six interviews to help reduce my initial anxieties and enabled a more confident approach to the study.

3. Personal Reflections: Surprises, Challenges and Learning Outcomes

One aspect of the interviews that surprised me was how open the participants were in sharing their experiences of depressive symptoms. In the Nairobi Ismaili community, awareness of mental health is still a work in progress and problems such as depression tend to be concealed. However, in the current study, I noticed that all participants talked openly about their experiences of depression and the impact it had on their lives. Participants also openly discussed attending counselling, something most Ismailis prefer to keep to themselves. Perhaps knowing that the researcher was also a counselling psychologist may have made them feel comfortable to share these experiences. A second aspect that surprised me was how openly participants shared their negative opinions about God, the religion and the community during the interviews. Being a member of the same religious community as the participants, I was surprised at how participants so honestly shared experiences such as not wanting to interact with the community, feeling angry towards God and ceasing prayer. One possible reason for this could be an increase in confidence following their recovery from the depressive symptoms to express their opinions directly and openly. Additionally, participants may have felt comfortable and safe with me to express these views and experiences. Nevertheless, the participants' openness not only surprised me but I felt a very

high regard for them for the courage it took to share such personal information with another Ismaili, and I felt honored to have been a part of this.

Being a member of the Ismaili community as well as a researcher investigating depressive symptoms in this community was a unique experience. It made it easier for me to understand certain religious and cultural concepts being described by the participants and gave me an opportunity to understand the experience of depressive symptoms in my community from a researcher's perspective. On the other hand, I experienced a challenge in being able to keep a balance between the two roles. Thus, I noticed that sometimes in the interviews, I would become so engrossed in the formalities of research that I would forget to be myself and to allow the learning process and interactions to take place naturally. At other times, I found myself becoming so comfortable listening to participants' accounts and experiences, that my role as researcher would be lost in the background and gently bringing it back was a conscious effort. Another challenge was refraining from making assumptions about my participants simply because I was a counselling psychologist and an Ismaili. For instance, while I initially assumed that participants would be willing to share their experiences of depressive symptoms and religious coping with me, I realized during the interviews that they did not necessarily share more or less information simply because we shared a cultural and religious background. Rather, each participant made that choice individually, and while all were willing to open up, some used more discretion than others.

Regarding the analysis process, as mentioned earlier, this was initially a daunting task for me. However, as the process continued, it gradually became easier and less stressful as large amounts of information were organized into manageable sections. One part of the analysis that I initially struggled with was the coding and development of themes. When I had transcribed all the interviews and stepped back to look at the volume of information in front of me, I wondered how I would organize this information into meaningful units without losing my participants' voice. Thus, I was concerned about analyzing the data without imposing my own beliefs, attitudes about depressive symptoms and religious coping on it. There were three ways which helped me to maintain a sense of objectivity during the analysis process and refrain from making assumptions about my participants to the best of my ability. One was to constantly refer back to the original research questions.

Having those questions in mind gave me a framework with which I could highlight comments from the participants' accounts that were meaningful and applicable to these questions. The second way was to to keep a journal, where I noted down my feelings about the interviews, my own connection with my religion, thoughts about my participants' accounts and how they impacted me. The journal helped me to maintain a sense of inner balance which in turn helped me to remain open when interviewing my participants and reading their transcripts. The third way was to discuss the codes and emerging themes with a fellow doctoral student and with my supervisor. The use of supervision was extremely beneficial as it helped me to engage in the analytical process more objectively, and reading articles by Yardley (2008) helped me learn how to improve the quality of my research. Consequently, I found myself enjoying the research process, learning from it, and engaging with it more naturally.

4. Conclusion

In conclusion, there are many lessons I have learned over the research process. For instance, exploring participants' experiences and how they made meaning of them, in rich detail helped me gain tremendous insights into the experiences of depressive symptoms among adult Ismailis and how religion influences the way they cope with it. Also, keeping a strong focus on the quality of the study has helped me appreciate the complexities of interpretation and rigor of ensuring credibility. Third, keeping a journal enabled me to become more aware of my own thoughts, feelings, assumptions and experiences in relation to the current study. Through this process, I not only learned about myself, but also how I can use this knowledge to try and be objective when interpreting information accounted by other people. Additionally, the findings of the current study will no doubt add valuable research to the existing literature on depressive symptoms and religious coping among Ismaili adults, a field that is under-researched, and inform therapeutic practices when working with this clientele. Lastly, the valuable lessons I have learned through the research process will enhance my own therapeutic work as I come to appreciate the influences that Ismailism has on depressive symptoms and how this can be adaptively incorporated into therapy when providing psychological support to members of this community.

References

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: SAGE Publications Ltd.

Yardley, L. (2008). Demonstrating Validity in Qualitative Psychology. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed) (pp. 257-272). London, UK: SAGE Publications Ltd.