The significance for Public Health of the relationship between spirituality and health, as reported by people identifying as 'Spiritual but Not Religious.'

by

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Thesis submitted

for the Degree of Doctor of Philosophy

2022

Abstract

Aim: How do self-identified healthy people who also identify as Spiritual but Not Religious report the relationship between spirituality and different dimensions of their health? **Objectives:** 1) To ascertain the participants' self-perception as to whether they were healthy or not; 2) To explore the definition of spirituality from the participants' perspective; 3) To explore the spiritual practices of the participants; 4) To explore the reported relationship between the participants` spiritual beliefs and their health; 5) To explore whether demographic factors (specifically gender, age, education, income, ethnicity and place of birth) can impact spirituality and the participants' health. **Methods:** This exploratory study uses a pragmatic mixed-methods approach, including an online questionnaire (n=917) and follow-up interviews (n=24). **Results:** Participants perceived spirituality to have positive effects on their physical, mental, emotional, and spiritual health but that the impact on their social and societal health was varied (but overall, still positive). The described benefits were: increased motivation and engagement with physical activity, improved diet, better quality sleep and greater peace of mind. The perceived undesirable effects were reported to be increased stress, rumination, and a decreased desire to engage with others. Themes derived from the results of this study led to the development of a Spiritual Health Effects Map (SHEM), which could potentially be used to complement Public Health practice in the UK. This map identifies six themes of spirituality: connection, self, beliefs, values, deeper awareness, and experiences, and outlines how these themes can relate to different aspects of health. **Conclusion:** The findings indicate that the reported impact of spirituality on health can be significant for people. This research helps raise awareness of how some people's spiritual beliefs affect their health and has fundamental implications for future research and practice within Public Health.

Keywords: Spirituality, Public Health, Mixed Methods, SBNR, SHEM, United Kingdom.

Please note I have Dyslexia. Please excuse poor spelling, grammar and sentence structure within this thesis.

Acknowledgements

I wish to thank a wide range of people for their support and guidance in the completion of this thesis. Firstly, the Women in Academic Support Network group (WIASN), who provided me with much-needed support throughout this journey. I am very grateful to my two wonderful supervisors, Professor Douglas MacInnes and Dr Jennifer Hardes, and Canterbury Christ Church University, who gave me the courage to try. There are a team of people to whom I would like to express my appreciation: Heather Thundow, Miles Greenford, Tristi Brownett and Jane Owens. I also wish to express profound gratitude to Alex and Sookie, who provided me with their much-needed company throughout the PhD process. I would also like to thank my two viva examiners, whose helpful comments did much to improve this thesis. Lastly, this study would not have been successful without all of the participants who gave up their valuable time to assist me with my research.

Publications and presentations arising from or relating to PhD thesis

Conference Presentations

Holt, N. (2018) 'Spiritual Experiences and Health: Perceived effects of spirituality on the health of the those who identify as Spiritual but Not Religious (SBNR) in the UK?' paper presented at the future study of religious and spiritual experience Conference in Wales. July 2018.

Holt, N. (2017) 'How Spirituality Influences some People's Health' paper presented at the Spirituality and Mental Health symposium presented at Huddersfield University. July 2017.

Holt, N. (2017) 'God's Pack: 'Transcending Conventional Theology and Wellbeing' paper presented at the Arts and Humanities Conference at Canterbury Christ Church University. June 2017.

Holt, N. (2017) 'Spirituality and Peoples Wellbeing' paper presented at the Interprofessional Education: Sharing Research and Practice Conference at Canterbury Christ Church University. January 2017.

Holt, N. (2016) 'Wild Places and Healthy Spaces' paper presented at the British Association for the Study of Religions (BASR) conference. September 2016.

Holt, N. (2015) 'Concept Analysis of Spirituality' paper presented at spirituality in the 21st Century' Conference in Lisbon, Portugal. March 2015.

Publications

Holt, N. and Greenford, M. (Sept 2022) 'Realising Potent Complexities of Women Being Spiritual and Healthy'. In Bennet et al. (Sept 2022) *Woman and Religion in Britain Today.* London: Vernon Press.

Holt, N. and Walker, P. (2017) Comfort, Christ and man's best friend: The 'new' Christian role for therapy dogs. *Theology*, *120*(6), pp.432-439.

Holt, N. (2016) 'What Does the Word Spirituality Really Mean?' In Mata-McMcMahon, J., Kovac, T and Miller, G. (2016) *Spirituality an Interdisciplinary review.* Oxford: Interdisciplinary Press.

List of Abbreviations

CASP	Critical Appraisal Skills Programme
CCCU	Canterbury Christ Church University
DH	Department of Health
HIV	Human Immunodeficiency Virus
ISC	Interfaith Spiritual Care
MeSH	Medical Subject Headings
NHS	National Health Service
NICE	National Institute of Clinical Excellence
ONS	Office of National Statistics
PEO	Population Exposure Outcome
PHSKF	Public Health Skills and Knowledge Framework
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD	Post Traumatic Stress Disorder
QOL	Quality of Life
RCT	Randomised Control Trial
R/S	Religious/Spiritual
RSIs	Religious and Spiritual Interventions
SBNR	Spiritual but Not Religious
SHEM	Spiritual Health Effects Map
SME	Spontaneous Mystical Experience
S/R	Spiritual/Religious
UK	United Kingdom
UKPHR	United Kingdom Public Health Register
USA	United States of America
WHO	World Health Organisation

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Chapter One

Introduction

1.0 Introduction

This first chapter presents the purpose for the study (from both a personal and professional interest), with a brief overview of the context of this thesis. It introduces the principle of Public Health in the United Kingdom (UK), the role of Public Health practitioners, the evolution of spirituality, key definitions of spirituality and religion, and a rationale for why spirituality is considered a more encompassing term than religion. Additionally, this chapter considers the rise of the term Spiritual but Not Religious (SBNR). This chapter then discusses spirituality and its relation to healthcare (including government policy), with a final summary. The thesis aims and objectives (and an overview of the thesis structure) are presented at the end of this chapter.

The focus of this thesis is to provide insight, from a Public Health perspective, into the reported relationship between spirituality and health of those who identify as SBNR. This thesis is intended for Public Health practitioners, which is defined as those who specifically work in the field of Public Health, discussed in more depth in section 1.2.1, whether that be health promotors, educators/researchers, or primary care workers (for example, social prescribers/link workers). At various points in the thesis, there are references to different areas of Public Health. The field of Public Health is wide, and the insights from this research are relevant across a broad range of areas of Public Health. This thesis is a conceptual work that provides a deeper understanding that might help complement Public Health practice, and which contributes a new perspective in order to examine the relationship between spirituality and health.

1.1 Personal and professional interest in the study of spirituality and Public Health

It is important to start this thesis by recognising my position on spirituality and perspective during the writing process. I developed a strong interest in spirituality in Public Health at a very young age. I had a British state school education. I grew up in an English seaside town in East Sussex, in the early 1990s, on a council estate where there were multiple levels of deprivation; teenage pregnancy was high, smoking was expected, and being overweight seemed to be normal. I knew this was not a life I wished for myself. I have always wanted to impact the world positively from a young age.

I grew up in a non-religious household. As a teenager, I suffered a great deal of anxiety. To help deal with this, I went to meditation classes, where my love of people's spiritual beliefs and practices started to develop. I also watched light-hearted programmes that included themes around people's beliefs,

such as ‘The Vicar of Dibley’ and ‘Father Ted’, on television as often as I could. Following the 1990s aerobic fitness trends, many entrepreneurial-minded exercise gurus took to the airwaves, intending to convince the public to buy their complicated contraptions, such as ‘Thighmasters’. Then, in the early 2000s, Mindfulness-Based Cognitive Therapy became popular. Public Health messages about improving a person’s health were regularly promoted. All these factors shaped my upbringing and personal philosophy, which led to my interest in spirituality and my development as a Public Health practitioner/researcher in this field.

I achieved a combined first-class honours degree in Health and Religious Studies. Several vital aspects of this degree influenced me. One example is a quote from Elizabeth Blackwell, one of the first female doctors. Blackwell discussed the role of health practitioners in the context of Public Health*:*

‘*We are not tinkers who merely patch and mend what is broken….* W*e must be watchmen, guardians of the life and health of our generation, so that stronger and more able generations may come after*’ (Blackwell, 1831 in Bennett, 2009).

Quotes like this caught my attention, leading me to be more interested in people's beliefs, and why and how people displayed some behaviours and not others. This solidified my career aspiration to be a Public Health practitioner. Through my undergraduate training, it also became apparent that little time was explicitly spent exploring people's beliefs about their health.

I then studied for a master's degree in Public Health/Health Promotion. At the same time, I worked as a live-in carer, a healthcare practitioner, and a play support worker. I taught Public Health at university level, and conducted research within this field, which I still do. I also had, and continue to have, a personal interest in living a happy eco-friendly life. My pursuit of spirituality and happiness led me to be interested in others' spiritual beliefs. I came across the label of Spiritual but Not Religious (SBNR). I felt this was a label that encompassed my own beliefs and understanding of spirituality. Thus, this research journey began in my personal and professional life, complemented by other questions: what is the difference between spirituality and religion? How important are these for improving people's health and wellbeing? Are they part of people's happiness?

With these questions in mind, I embarked on a PhD. I began by exploring the literature, and I was surprised to find that: 1) most of the research about spirituality and health was conducted in the United States of America (USA); 2) the literature focused on religion rather than spirituality; 3) many of the studies were conducted on those people who reported to be sick or had a disability; 4) there was little existing literature on the role of spirituality within Public Health in the UK. Therefore, I began

immersing myself in the literature of spirituality, distinguishing it from religion, and understanding the relationship between the two.

I examined the literature looking at the relationship between spirituality and health. However, the clarity of the terms' spirituality' and 'health' were explored before doing so. I identify as an SBNR person myself, which means I engage with spiritual activities (in my case, yoga and meditation), without any formal connections to religion. For me, there is no supernatural element. I engage with yoga and meditation every day. I perceive these to be spiritual but not religious activities.

Finally, it is essential to note that I have dyslexia, which I was diagnosed with at university. This learning disability affects my writing and sentence structure (as well as my speech and information processing, but, hopefully, these aspects of my disability are less apparent within this thesis). It is essential to say this at the beginning of my research, as this would never be an error-free thesis. Nonetheless, I believe this thesis contributes to the growing body of research in the field of spirituality within Public Health. It is hoped that, as education moves to be more inclusive, my achievement in completing a PhD will hopefully inspire other dyslexic students to do the same.

1.2 Public Health in the UK

According to the World Health Organisation (WHO) (2019), Public Health is defined as 'the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society'. It focuses on the social, economic and cultural factors that shape the health of populations (Scriven, 2017; WHO, 2019). In the UK, the overarching role of Public Health is to prevent, promote, protect, and improve the health of individuals, communities, and populations, and to reduce health inequalities (Faculty of Public Health, 2021; McClean et al., 2019; Nutbeam, 1998; Public Health England, 2021). Public Health supports individuals, organisations, and society to tackle preventable disease, mortality, and disability. This is prominently actioned through policy, practice education, and research (Mancuso, 2008; Nutbeam, 1998; Nutbeam, 2000; Scriven, 2017; WHO, 2019).

The role of Public Health in the UK is to implement relevant policies and encourage positive health practices. The Public Health Skills and Knowledge Framework (PHSKF) was developed through the collaborative efforts of lead agencies in Public Health across the UK to deliver on Public Health outcomes (Public Health England, 2017). The PHSKF (2021) describes generic activities and functions undertaken by the Public Health workforce in the UK; this is illustrated as an architectural map presented in Figure 1.

Figure 1: Public Health Skills and Knowledge Framework (PHSKF)

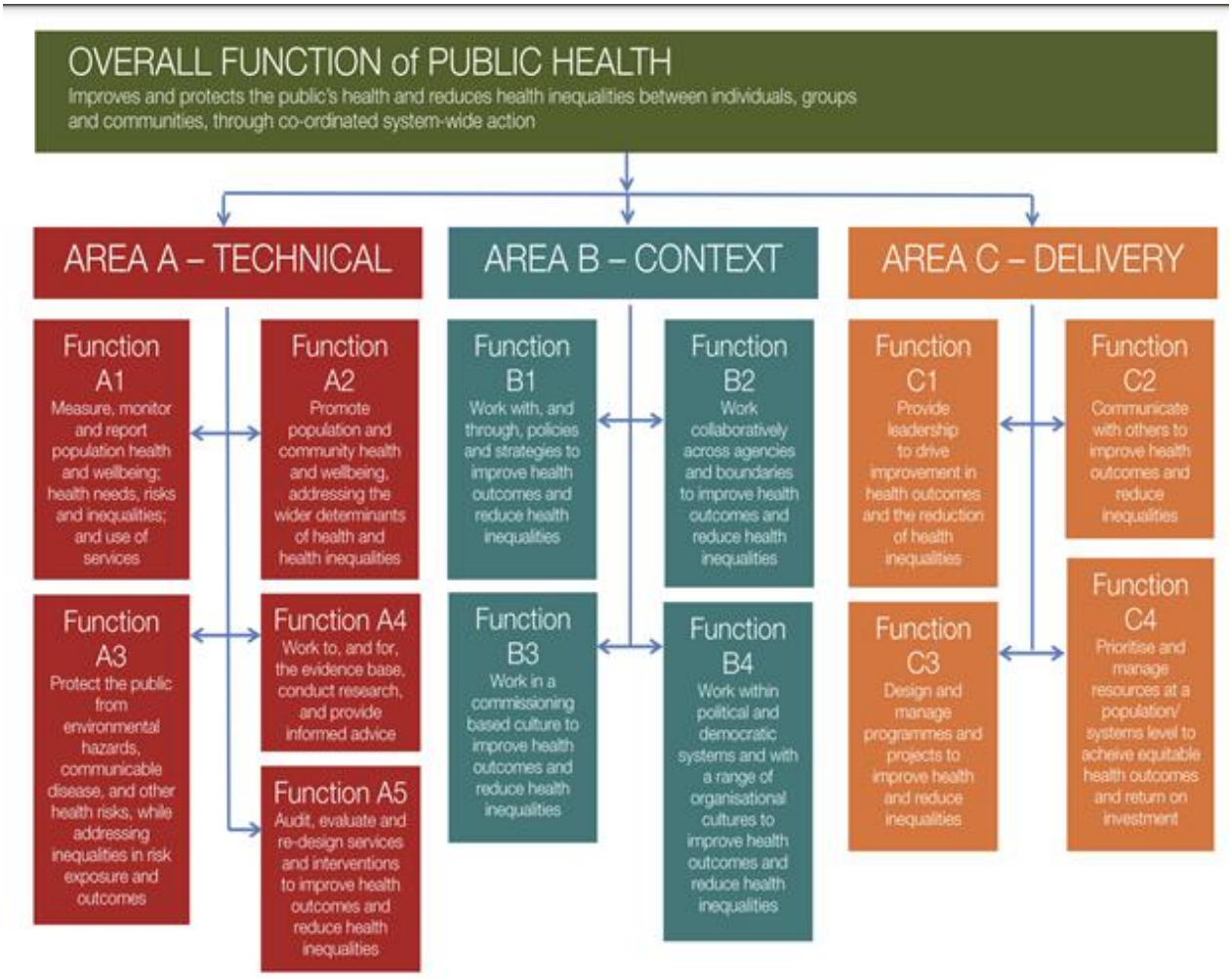


Image from Public Health Skills and Knowledge Framework (2016) *The Overall Function of Public Health.* Available at: publishing.service.gov.uk (Accessed 26 August 2021).

The PHSKF (2016) framework is presented as a hierarchy of functions, divided into three main areas: A) Technical: how data and intelligence is sourced and used; B) Contextual: how Public Health action is informed by policy and strategy from national government agencies and other authorities, or how it is implemented strategically across a system through the development of local strategies and policies; and C) Delivery: the activities associated with the leadership of different groups, situations, settings, and intentions. This includes leading and managing others, changing systems, establishing collective buying and ownership, and setting strategic visions. This framework underpins and guides all those who work within the sector (Public Health England, 2017). The framework aims to implement good Public Health practices, and to be clear regarding the functions of Public Health (Faculty of Public Health, 2021). Nevertheless, the PHSKF has been criticised for being too broad, and it is sometimes

challenging to see how it can be successfully utilised in practice. Despite these limitations, for this thesis, PHSKF provides a conceptual outline of the overall functions of Public Health.

The difference between Public Health and other health fields, although there is a relationship between Public Health and other health disciplines, is that Public Health predominantly focuses on wider societal issues on an individual, community, and national level (Smith and Petticrew, 2010). Therefore, the Public Health perspective, particularly for this study, is broad and encompasses a wide range of components within this field.

1.2.1 Public Health Practitioners

According to the National Health Service (NHS) (2021), the term 'Public Health practitioner' is used to describe 10,000 members of the core workforce who work in various areas of Public Health, including health improvement, health protection, and health and social care quality. Public Health practitioners work across public, private, voluntary, and community sectors (NHS, 2021). Even though they work in different areas of Public Health, these practitioners all contribute to improving people's health and wellbeing (NHS, 2021). Public Health professionals focus on the entire spectrum of health and wellbeing, rather than only on the eradication of diseases; this focus is responsible for some of the most critical health and social gains in the UK. The roles of these professionals are multidisciplinary, and they are responsible for individual and population-level interventions, including sensitive and deeply personal issues (NHS, 2021; United Kingdom Public Health Register (UKPHR), 2012), as illustrated in the PHSKF workforce.

In the UK, the role of Public Health practitioners is to work in many places and many areas of Public Health (illustrated in Figure 1). Practitioners may support healthy lifestyle programmes and charities, helping individuals and groups, for example, to stop smoking, with weight management, or to take more exercise (NHS, 2021). They may work on immunisation programmes and screening, based in local communities or Public Health teams specialising in health protection (NHS, 2021). Some Public Health practitioners play an essential role in national and local health campaigns. Others may work in the Public Health knowledge and intelligence teams in local government organisations and Public Health England, such as a Public Health consultant, services co-ordinator, or a social prescriber (NHS, 2021; UKPHR, 2012).

1.2.2 The ethos of Public Health

Although the roles of Public Health professionals may vary, as previously stated, the main aim of Public Health is preventing disease, prolonging life, and promoting health through the organised efforts of society (Scriven, 2017; WHO, 2021). Public Health is based on the principles of equity, fairness and inclusiveness, empowerment, effectiveness, and evidence-based practice (Shukla, 2010). Public Health practitioners share the commonality of trying to 'holistically improve people's health', generally by adopting a 'person-centred approach' (Ethics of Public Health, 2021; UKPHR, 2012). This approach means that the individual is placed at the centre of the service and treated as a person first (Mental Health, 2021).

The strength of this person-centred approach is that it promotes a collaborative approach between health professionals and service users (Collins, 2014; Health Foundation, 2014). It is about working 'with' people rather than doing things 'to' them, and focuses on the individuals needing the care (Collins, 2014; Health Foundation, 2014). However, this approach is not without its critics; Arnold, Kerridge and Lipworth (2020) argue that there is limited evidence that a person-centred approach improves healthcare experience or outcomes. Others, such as Cook (1998), Mental Health (2021) and Titler (2006), have contradicted this point. They argue that a 'person-centred approach' puts the people accessing service at the centre, treating them with care and support as equal partners (Health Innovation Network, 2018; PHSKF, 2021; Public Health England, 2021). Generally, this approach provides Public Health services that put the needs of individuals, communities, and counties before making assumptions about the needs and protecting people's health on a broader level (Public Health England, 2021).

A person-centred approach tends to be underlined by 'evidence-based practice', which is the conscientious and judicious use of current best evidence in conjunction with clinical expertise and service user values to guide healthcare decisions (Cook, 1998; Jennings and Loan, 2010; Titler, 2006). This contributes to improving people's health on both an individual and societal level. An advantage of evidence-based practice is the ability to evolve and individualise the care of people, reduce the cost of healthcare, and enhance the expertise of healthcare professionals providing the care (Titler, 2008; Titler, 2006). Mitchell (1997), however, has criticised evidence-based practice for failing to clarify and make the underlying assumptions and frameworks explicit, making the combining or contrasting of studies problematic. Mitchell's (1997) point is supported by Pellegrino (2002), who argues that, due to the demands of practice articulated in the public media, there is an urgency to transform information into evidence uncritically. Despite these limitations, evidence-based practice has done much to advance healthcare, enabling all methods of care to be based on the best available credible

evidence (Titler, 2006; Titler, 2008). These are some of the premises Public Health practitioners work from.

1.3 Contemporary spirituality

To frame the context of spirituality for this thesis, the next section discusses four areas: 1.3.1 the evolution of the concept of spirituality; 1.3.2 key definitions of spirituality and religion and their relationship to healthcare literature; 1.3.3 the move towards spirituality as a more inclusive term; and, finally, 1.3.4 the rise of the term Spiritual but not Religious (SBNR).

1.3.1 The evolution of the concept of spirituality

Sheldrake (2013) states that the term 'spirituality' originally derives from the Latin *spiritualitas*, which corresponds to the Greek *pneuma*, 'spirit', and its adjective *pneumatikos*, as they appear in the Pauline Epistles. Bergomi (2018) and Carrette and King (2011) propose that the more contemporary understanding of spirituality was developed throughout the nineteenth and twentieth centuries, mixing Western esoteric traditions alongside elements of Eastern traditions. The Western (West) and Eastern (East) divide, refers to how traditionally countries are split up via their belief systems; the West was dominated by Christianity, and the East, by teachings that derive from Hinduism, Buddhism and Taoism (Hasa, 2016).

The modern Western perception of the term 'spirituality' was first recognised in the 1960s, as increasing numbers of people turned to spirituality, rather than religion, as a source of solace and sanctuary from the busy consumer world (Hay and Hunt, 2000; Roof, 2001; Tischler, 1999). Harvey (1989, p.171) states that the rise of 'spirituality', as something separate from religion, was part of the late capitalist cultural shift, 'from the collective norms and values that were hegemonic in the 1950s and 1960s, towards a much more competitive individualism as the central value in an entrepreneurial culture that has penetrated many walks of life'.

Crossman (2019) and Gauther (2017) argue that this cultural shift is down to secularisation, a cultural transition in which religious values are gradually replaced with non-religious values. This is due to the joint rise and globalisation of consumerism and neoliberalism. Consumerism is the idea that increasing the consumption of goods and services purchased in the market is always a desirable goal, and that a person's wellbeing and happiness depends fundamentally on obtaining consumer goods and material possessions (Czarnecka and Schivinski, 2019). Neoliberalism is a political approach that favours free-market capitalism, deregulation, and reduction in government spending (Vincent, 2009). Consumerism became a phenomenon in the mid-twentieth century, starting in the late 1950s and

developing throughout the 1960s (Carrette and King, 2011; Crossman, 2019; Gauther, 2017). It was not only an economic phenomenon, but also a cultural and social revolution (Gauther, 2017). From that period onwards, the consumption of objects and services became a vehicle for expressing personal identity, including people's spiritual beliefs and practices. For the first time, people could 'cherry pick' which parts of the religion they wanted (Carrette and King, 2011). This is further supported by Taylor (2002), who argues that mass consumption provided a formidable vehicle for the democratisation of the culture of authenticity and expressivity, according to which every individual is thought of as having a unique self, and that finding and realising this self-constitutes the very meaning of life. Among other factors, the declining membership of organised religions and the growth of secularism in the Western world have given rise to this broader view of spirituality (Carrette and King, 2011; Hogan, 2010). However, there are some issues with this, as it suggests that spirituality is a notion that can be 'bought and sold' (meaning spirituality can be seen as a commodity); therefore, spirituality can lose part of its roots, authenticity, and culture (Brzosko, 2019).

This can also be seen to be reflected in British society, as between 2001 and 2011, the proportion of the public identifying as religious decreased, and the proportion of those who reported to be non-religious increased by 25% (Office of National Statistics (ONS), 2017). The British Social Attitude Survey (2019) shows a shift towards non-affiliation, with 52% of the public now saying they do not regard themselves as belonging to any religion (Curtice et al., 2019, p.18). The ONS (2017) reported that a quarter of the population (14.1 million people) in England and Wales stated that they had no religious beliefs in 2011. However, when this non-religious category is explored in more detail, it suggests that some members of the public are not aligning with a specific religion but do still have spiritual tendencies (Parsons, 2018; Welker, 2010). A plausible reason why this might be the case is a change in societal culture, which was identified by Crossman (2019) and Gauther (2017), as discussed above. Therefore, this all contributed to the rise of the 'spiritual but not religious' (SBNR) category, as some people want to feel a sense of belonging, but one that does not explicitly include religious faith, which is discussed in more depth in section 1.3.4 (Fuller, 2001; Mercadante, 2014; Parsons, 2018).

Although some could see SBNR as a universal phenomenon, there is significant research to suggest that this emergence is due to societal and cultural problems, as some people may feel more disconnected, lonely, and more fragmented in their personal lives, with little sense of connectedness or community (Beck, 2012; Bellah et al., 1985; Carrette and King, 2005; House, Landis and Umbertson, 1988). Hence, the increasing number of people feeling a spiritual need but rejecting a religious commitment in this modern world is perhaps inevitable (Parsons, 2018). Welker (2010) suggests that people reject religious commitments because some feel stunted and restricted by religious teachings

which contradict modern metaphysical and ethical ideals. Others are frustrated by repetitive services that bear no relationship to their actual lives, when they crave meaningful intellectual stimulation, or simply resent being bored (Welker, 2010). Consequently, all this information needs to be taken into account when considering the evolution of the concept of spirituality.

1.3.2 Key definitions of spirituality and religion within the field of health

Following on from this, it is necessary to provide some examples and analysis of the key definitions of spirituality and religion within the health literature.

Spirituality

To set the context of this thesis, this introduction chapter draws on McSherry and Cash's (2004) discussion of the evolution of the term spirituality over the last thirty-five years (illustrated in Figure 2). This paper was chosen because McSherry and Cash are renowned for their research in the field of spirituality and health. This particular paper has been widely cited and provides some of the most known definitions of spirituality in the context of health.

Figure 2: Definitions of spirituality in healthcare spanning the last two decades

Author(s)*	Definition
Stoll (1989, p.6)	Spirituality is my being; my inner person. It is who I am–unique and alive. It is me expressed through my body, my thinking, my feelings, my judgments, and my creativity. My spirituality motivates me to choose meaningful relationships and pursuits. Through my spirituality, I give and receive love; I respond to and appreciate God, other people, a sunset, a symphony, and spring. I am driven forward, sometimes because of pain, sometimes in spite of pain. Spirituality allows me to reflect on myself. I am a person because of my spirituality–motivated and enabled to value, to worship, and to communicate with the holy, the transcendent.
Murray and Zentner (1989, p.259)	A quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any good. The spiritual dimension tries to be in harmony with the universe, and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death.
Males and Boswell (1990, p.35)	It is not easy to define spirituality since it concerns the way in which men and women may understand their existence and the action which comes from an understanding; the knowledge of things both within an individual and of the existence and importance of things beyond him or her. It is important to point out this knowledge is not the grasp of intellectual facts but rather a reverence for mysteries of life which no-one can fully understand. It is not, therefore, something which can be regarded as being unattainable for people with learning difficulties.
Reed (1992, p.350)	Spirituality refers to the propensity to make meaning through a sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual. This relatedness may be experienced intrapersonally (as a connectedness within oneself), interpersonally (in the context of others and the natural environment) and transpersonally.
Tanyi (2002, p.506)	Spirituality is a personal search for meaning and purpose in life, which may or may not be related to religion. It entails connection to self-chosen and/or religious beliefs, values and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace, and empowerment. The results are joy, the forgiveness of oneself and others, awareness and acceptance of hardship and mortality, a heightened sense of physical and emotional wellbeing, and the ability to transcend beyond the infirmities of existence.

* The full reference list is in Appendix 1.

Table adapted from McSherry, W. and Cash, K. (2004) 'The language of spirituality: an emerging taxonomy.' *International journal of nursing studies*, *41*(2), pp. 151-161.

Figure 2 shows some of the most commonly cited definitions of spirituality. There are similarities between these definitions, for example, 'connection', 'transcendence', and 'self' are discussed in all of them. However, McSherry and Cash (2004) suggest that spirituality can be defined and interpreted differently, due to many definitions having several layers of meaning or defining characteristics. McSherry and Cash (2004) discuss how these definitions have become more inclusive over time due to the embedding of spirituality within healthcare. To further support the definitions found by McSherry and Cash (2004), Puchalski et al. (2003, p.10) (who has also written extensively in and cited the field of spirituality and health) reviewed the health literature and proceeded to define spirituality

as 'an essential element of humanity'. 'It encompasses individuals' search for meaning and purpose; it includes connections to others, self, nature, and the significant or sacred; and it embraces secular and philosophical, as well as religious and cultural beliefs' (Puchalski et al., 2003, p.10). Therefore, bringing these few selected definitions of spirituality together, further highlight spirituality as attempting to be an inclusive term within healthcare.

Zinnbauer and Pargament (2005, p.21) also note that 'spirituality has come to mean many things in popular usage and is often understood differently by different people'. Fisher (2011) and Huss (2014) further supported this, by arguing that the meaning of spirituality has developed and expanded over time, and various connotations can be found alongside each other. This has been echoed by other researchers within the field of health (Fisher, 2011; Jones, 2016; Oman, 2018). Jones (2016) also adds that the word 'spirituality' can be seen as nebulous and often lacks clarity in its application. These factors have affected how key definitions of 'spirituality' have been developed and measured over time within health.

Reinert and Koenig (2013), and Swinton (2006) have criticised the health literature for the inconsistent definitions that make it difficult to measure health outcomes related to spirituality, an issue which is discussed in more depth in the literature review. Many critical voices have challenged the current conceptualisations of spirituality, particularly for research purposes (Reinert and Koenig, 2013; Swinton, 2006). Along with these criticisms, abstract terms such as subjective happiness, subjective wellbeing, and Mindfulness may or may not be included when defining and measuring spirituality. For example, for some people, terms such as Mindfulness can be a form or practice of spirituality, while for others, Mindfulness is secular and separate from spirituality (Brown, 2016). These associated terms can be challenging to define; therefore, spirituality can either include or exclude these definitions depending on the individual researcher.

Religion

Moreira-Almeida and Koenig (2006) suggest that current health researchers typically refer to religion as an organised system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent, such as God, a higher power, or ultimate truth/reality. Others have argued that there is a specific emphasis on a particular framework for public expression that includes a belief structure, a moral code, an authority constitution, and collective forms of worship (Hayes and Cowie, 2005; Idler et al., 2009; Koenig, 2004; Koenig, 2008). To further support this definition, the NHS (2021) define religion as 'a system of beliefs, including belief in the existence of at least one of the following: a human soul or spirit, a deity or higher being or self after the death of one's body'. Koenig (2012) points out that definitions of religion within healthcare are multifaceted and can involve a wide range

of perspectives, including religious beliefs, feelings, motivations, experiences, and behaviours. Koenig (2012), and Roger and Hatal (2018) also suggest that reaching a satisfactory consensus on definitions of religion is challenging simply because different researchers focus on different aspects of this multi-faceted concept. Therefore, this challenge/complexity needs to be considered when discussing the role of religion in health.

1.3.3 Reasons why spirituality is considered a more encompassing term than religion in health research

As illustrated above, spirituality and religion are usually defined as unique and distinct concepts in contemporary research in health (Crisp, 2016; Hodge, 2018). Some theologians have criticised this development of spirituality because there are still those who adhere to traditional values (Nelson, 2009). Nonetheless, the term 'spirituality' appears to be more frequently used than the term 'religion' in health (Canda, 2008; Crisp, 2016; Derezotes, 2006; Tuck, 2004). There are several plausible reasons why this is the case. First, it may reflect the western shift towards secularism in the twentieth century, as discussed in section 1.3.1, and an increase in popularity of the idea that spirituality can be unfettered from institutional, communal, and structured constraints which can be associated with religion (Smith and Denton, 2005; Villani, 2019; Zinnbauer et al., 1997). Secondly, it could also reflect society's current belief systems, and the fact that spirituality is seen as a broader term encompassing people's values (Crossman, 2019; Gauther, 2017). Spirituality can be perceived as more inclusive and encompassing, as a less restrictive language (Canda, 2008; Crisp, 2016; Derezotes, 2006; Tuck, 2004). Some scholars such as Ammerman have made a further distinction by claiming spirituality is often viewed as an individual essence expressed through thoughts, feelings, and behaviours that make meaning, peace, hope, and connection, whereas religion is seen as ritualistic and impersonal (Ammerman, 2013; Gall et al., 2011; Tuck, 2004).

Derezotes (2006) claims that religion tends to be conceptualised as a socially shared set of beliefs and practices that can be, but is not necessarily, related to spirituality. Villani (2019) and Paley (2008) argue that the conceptual terrain covered by spirituality has grown significantly over the last fifty years due to it being considered more inclusive. Hence, this is another plausible reason why people have moved away from using the term religion and towards the term spirituality within healthcare and broader society. Even with these limitations discussed above, it is evident that there has been an increase of the use of the term ‘spirituality’ within health literature.

1.3.4 Spiritual but Not Religious (SBNR)

The term 'Spiritual but Not Religious' (SBNR) was first recognised in literature in the 1960s, which is discussed in more depth in the literature review. Increasing numbers of people had turned to spirituality, rather than religion, as a source of solace and to find sanctuary from the busy consumer world (Hay and Hunt, 2000; Roof, 2001; Tischler, 1999). However, Parsons (2018) argues that the term SBNR arose in the 1980s, when it became more socially acceptable to identify as SBNR, as some people still had spiritual tendencies but did not want to be tied to one specific religion. Drescher (2014, p.3) suggests that, in the 1980s, 'the designation SBNR became part of the popular lexicon as a distinctive marker of spiritual identity and practice'. By the late 1990s and early 2000s, the phrase 'Spiritual but Not Religious' appeared in mainstream literature as a search for meaning and fulfilment, which was uncoupled from particular institutional or dogmatic commitments (Drescher, 2014). Generally, those who align with SBNR tend to have concerns with organised religion (Hastings, 2016; Mercadante, 2014; Smith, 2020).

1.4 Spirituality in healthcare

Healthcare is defined as the maintenance or improvement of health via the prevention, diagnosis, treatment, amelioration, or cure, of disease, illness, injury, and other physical and mental impairments in people (NHS, 2021). Considerable research explores the links between spirituality and health, but this often neglects those outside mainstream religious traditions, such as those who identify as SBNR, especially in the UK, as this thesis will go on to show. There has been substantial research on spirituality and health within some health disciplines such as medicine, nursing, and occupational therapy (Koenig, 2013; Koenig, King and Carson, 2012; Oman, 2018; Reinert and Koenig, 2013). However, although there is growing support for a more holistic Public Health practice, spirituality is not often deemed a priority (Egan and Timmins, 2019).

Oman (2018, p.2) posits that 'to its detriment, the field of Public Health has ignored the enormous body of empirical evidence that now links religious and spiritual factors to better health'. Discussing this in the context of the USA, Oman (2018) argues that there are several explanations as to why Public Health has largely ignored spirituality. He suggests that senior academics have struggled to be impartial in recognising and absorbing evidence with any spiritual/religious connotations, as, historically, they have embedded secularisation theories. Furthermore, others may feel the subject of religion and spirituality is beyond their expertise due to a lack of education and personal experience. Oman (2018) claims that some Public Health professionals may have never come across spiritual matters in the context of health, or that spirituality has been oversimplified to the point where it has

been incorporated into other factors such as social support. When analysing from a UK perspective, this is a plausible explanation as to why spirituality seems to be prominently absent from the field of Public Health. Universally, spirituality is difficult to define and can be personal (Jones, 2016; Spencer, 2012); it is also challenging to consider from a professional viewpoint (Clarke, 2009; Hvidt et al., 2020). Therefore, to date, spirituality has been given little attention in Public Health education in the UK (unlike other disciplines such as nursing education). Consequently, it has not been implemented into wider practice.

1.4.1 Lack of recognition

Alongside this, some scholars argue that the need for healthcare providers to address the connection between spirituality and health is becoming more recognised, as more people desire spiritual content in their healthcare (Cobb and Robshaw, 1998; Egan and Timmins, 2019; Goddard, 2000; Wattis, Curran and Rogers, 2017). Rarely, however, are people asked what spirituality means to them or how they perceive spirituality to affect their health (Mental Health Foundation, 2018; Reinert and Koenig, 2013). This is further compounded by the fact that NHS funding is primarily spent on treating ill-health rather than prevention (The King's Fund, 2017); thus, the limited focus would indicate that supporting people's spiritual needs is not a priority (Egan and Timmins, 2019). This is even more true in the Public Health field, where spirituality is 'virtually absent' (Egan and Timmins, 2019, p.55). As further highlighted in the literature review (in section 2.6.2.1), past research has focused on spirituality in relation to individuals or specific groups of people, such as those who are terminally ill or undergoing mental health treatment.

1.4.2 Health promotion

Health promotion enables people to increase control over and improve their health (WHO, 1986). Although not formally recognised as a form of health promotion in the UK, there have been some organisations, such as 'Alcoholics Anonymous, Narcotics Anonymous, Al-Anon Family Groups, Gamblers Anonymous, Overeaters Anonymous and dozens of other '12 step fellowships' (Kelly and White, 2012), which 'inform or play a part in many otherwise secular treatment programmes and protocols' (Dossett, 2013, p.370). However, this approach could be criticised as fostering or encouraging spirituality, which can also be detrimental to health. Spirituality is used as part of the framework to follow in the recovery process and provide a higher purpose (Alcoholics Anonymous, 2021). Egan and Timmins (2019) note that the Ottawa Charter (the WHO international agreement on health promotion, created in 1986) states that 'spirituality could be effectively integrated into existing health systems and services, further lending to the creation of supportive environments'. Therefore,

it could be argued that the idea of implementing spirituality within health promotion is not 'new' but has not been fully applied to Public Health practice.

Part of this health promotion development within healthcare in the UK has been a rise in the use of 'Mindfulness', which 'is a form of meditation and technique that can be seen as a self-reflection phenomenon where one chooses to be fully present in the current moment (Birnbaum, 2008; Kabatt-Zinn, 2021; Raab et al., 2015). This has been used in healthcare in the UK as a form of health promotion to reduce stress reduction, burnout, and improve quality of life (Raab et al., 2015). Galla et al. (2015) found that mindfulness training programmes may offer a promising approach for general Public Health promotion by improving the urban community's stress management. Health organisations in the UK, such as the National Institute of Clinical Excellence (NICE) (2021) and the National Institute of Health (2021) discuss and promote the use of Mindfulness to improve health.

1.4.3 The conflict between spirituality and healthcare

There are also some conflicts between spiritual (and religious) and Public Health domains. For example, some people's personal spiritual beliefs can affect the choices they make about their health, such as choices about the foods they eat, engaging in risk-taking activities that can be detrimental to their health, and abstaining from health interventions, as they go against their personal beliefs (Isaac, Hay, and Lubetkin, 2016; Koenig, 2012; Oman, 2018). Research suggests that health practitioners and health planners are often too preoccupied with the immediate problems of those who have a disease or illness to pay attention to the needs of those who are 'well' (WHO, 2020). There have also been ethical issues of practitioners imposing their own beliefs onto services users for example, praying for patients when this has not been required by the service user, this could be seen as not appropriate professional conduct (Carlson et al., 2002; Richards and Potts, 1995; Shafranske and Malony, 1990).

1.4.4 Government policy and spirituality

Government policies and Public Health practitioners encourage society to implement 'good' health behaviour (Nutbeam, 2000; Szreter and Woolcock, 2004). In 2010, the Department of Health (DH) recognised the need to ensure that the spiritual and cultural beliefs of patients and their families were identified by both staff and broader organisations, such as the NHS. NICE (2016) proposed that it is essential for carers, community members, and hospital healthcare teams to recognise the importance of spirituality in people's lives. The DH (2011, p.1) stated that 'You can expect the NHS to respect your privacy, dignity and religious and cultural beliefs at all times and in all places'. In addition, the NHS (2011) recommends 1) inter-professional educational initiatives to enable a more comprehensive

understanding of the context and meaning of spiritual care, and its relationship to health among all healthcare staff; 2) promoting services that deliver spiritual care to people of any or no declared faith, community, or belief group; 3) use of the Chaplaincy Capability and Competency Framework in professional and personal development concerning the Knowledge and Skills Framework.

In 2008, the DH launched an 'End of Life Care' strategy for England and Wales, which recognised people's spiritual needs concerning end-of-life care. The policy aimed to achieve a comprehensive transformation of the attention given to people approaching the end of their lives, as well as their families and carers. The Annual Report of the End-of-Life Care Strategy (2011) identified that there was still significant work to do on meeting these spiritual needs. However, this care strategy was commissioned to address these problems, which were thought to inhibit the development of spiritual care in the NHS and other palliative and end of life care providers. Despite this, there appears to be a lack of implementation of the evidence concerning the spiritual care tools available and the knowledge and skills of the UK workforce to equip them to offer high-quality spiritual care (DH, 2011). Nevertheless, this strategy still shows the recognition of the spiritual practices that are currently being undertaken within healthcare.

The government has also released guidance on 'Culture, Spirituality and Religion: Migrant Health Guide (2017)'. One of the main messages of this guidance is 'expressed beliefs lead to differences in response to illness and disease, influencing health-seeking behaviour, interpretation, and ultimately diagnosis by healthcare practitioners.' It recommends to:

'*Recognise your own preconceived ideas that you may bring to professional encounters and aim not to make assumptions about anyone's beliefs or values, no matter what culture they belong to. Instead, ask patients about their own understanding and about what is important to them regarding their health issues, and why'* (Public Health England, 2017, p.1).

This report seemed to be aimed predominantly at medical healthcare practitioners as the language focuses on patients (Public Health England, 2017, p.1).

Similarly, NHS Scotland (2009) developed the 'Spiritual Care Matters' document, an introductory resource for all NHS staff in Scotland. Within this policy, they suggested three main points: 1) that the delivery of spiritual care to patients and their carers are the responsibility of NHS staff, working in partnership with those employed with specific responsibility, training, and skills in spiritual and religious care; 2) that spiritual care must be accessible to all who use the services; 3) that access to Spiritual Care is grounded in an ethos of respect, support, and compassion, and includes the availability of information and staff trained in spiritual care (NHS Scotland, 2009).

This vision was underpinned by NHS Scotland (2002), which developed the 'Spiritual Care Policy', which was published seven years earlier. This policy attempted to address the fundamental human need to have a sense of peace, security, and hope, particularly in the context of injury, illness, or loss. The policy states that: 1) spiritual care should be offered in a one-to-one relationship, be person-centred and makes no assumptions about personal conviction or life orientation; 2) religious care is an aspect of spiritual care and is ‘given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community’; 3) it is inappropriate for any member of staff to impose upon another person in the workplace their own religious beliefs, faith, or values (NHS Scotland, 2002). All these policies demonstrate how spirituality has been implemented within some health care policies and practitioners within the UK.

1.5 Chapter summary

This introduction has laid the foundations regarding the context of spirituality within Public Health in the UK. It has acknowledged my background as the researcher within this study. It has also established the role of Public Health practitioners and the ethos of Public Health. This study argues that the core of Public Health is improving people's health on individual, community, and population levels. This chapter then discussed the evolution of spirituality. Several key definitions of spirituality and religion have briefly been covered, including definitions by McSherry and Cash (2014). Some rationale was given for why spirituality is now considered a more encapsulating term than spirituality. The rise of the term' spiritual but not religious' (SBNR) has also been explored. This chapter has briefly highlighted the current relationship between spirituality and healthcare, including the potential lack of recognition of spirituality within health and health promotion, the conflict between spirituality and healthcare and UK government policy relating to spirituality and health. It has specified some of the policies that provide guidance on spirituality and health, such as the 'End of Life Care' strategy for England and Wales (2008)' and the 'Culture, Spirituality and Religion: Migrant Health Guide (2017)'. Finally, the policies identified demonstrate some of the ways in which spirituality has been implemented within some health care policies and practitioners within the UK.

1.6 Aim and objectives of this thesis

This thesis aimed to explore:

'How do self-identified healthy people who also identify as Spiritual but Not Religious report the relationship between spirituality and different dimensions of their health?'

To address this research question, five objectives were developed:

1) To ascertain the participants' self-perception as to whether they were healthy or not.

2) To explore the definition of spirituality from the participants' perspective.

3) To explore the spiritual practices of the participants.

4) To explore the reported relationship between the participants` spiritual beliefs and their health.

5) To explore whether demographic factors (specifically gender, age, education, income, ethnicity and place of birth) can impact spirituality and the participants' health.

1.7 Thesis structure and outline of the chapters

This thesis is organised into six chapters:

Chapter One is the introductory chapter, which has provided the background and the context of this study.

Chapter Two presents two literature reviews. First, a broad systematised review of spirituality and health examining the systematic literature on spirituality and Public Health. Second, is a narrower literature review focusing more specifically on the SBNR population and health. This chapter also includes the definitions proposed for this thesis.

Chapter Three is the methodology chapter, which includes a discussion on how the aim and objectives of the study which are going to be examined in this research. This chapter includes an initial discussion about methodology, my philosophical stance, data collection methods (questionnaires and interviews), how the data was going to be collected, sample, ethics, data analysis methods and a reflexivity section.

Chapter Four presents the results of the questionnaire and interview findings.

Chapter Five provides a discussion of the findings and illustrates a clearer understanding of how spirituality was reported to affect some people's health.

Chapter Six presents the conclusion, which brings together the whole thesis.

There is also a **Reference List** and **Appendices** containing supplementary documentation.

Chapter Two

Literature Review

2.0 Introduction

This chapter explores how spirituality is currently operationalised within the field of Public Health, and proposes the definitions used for the rest of this thesis. Operationalisation is the process through which (abstract) concepts (such as spirituality) are translated into (measurable) variables (Harvey, 2019; Jonker and Pennink, 2010; Sarantakos, 1993). For this study, two literature reviews were conducted; one was a broader review focused on spirituality and Public Health by exploring systematic reviews; the second was a narrower review focused on the SBNR population using a wider range of journal articles.

The chapter is divided into the following three sections: **section 2.1 – 2.8** is a broad literature review that examines the relationship between spirituality and Public Health, specifically focusing on systematic reviews. **Section 2.9 – 2.16** presents a narrower focused literature review of the SBNR population in relation to Public Health using peer reviewed journal articles. Finally, **section 2.17** examines the definitions proposed within this thesis. The rationale for presenting this chapter in three sections is that it is logical, appropriate to the discipline, and provides a firm foundation for the methodology.

Within Public Health, literature reviews aim to answer focused questions to inform Public Health practitioners, other health professionals, and patients of the best available evidence when making healthcare decisions (also known as evidence-based practice), influence policy, and identify future research priorities (Smith and Noble, 2016). There are many ways to conduct a literature review, although the field of Public Health tends to favour systematic reviews as they are considered the 'gold standard'; they attempt to identify, appraise, and synthesise all empirical evidence that meets specific inclusion criteria to answer a highly focused research question (Dixon-Woods et al., 2005; Orton et al., 2011; Paudel, 2012; Pope, Mays and Popay, 2007; Smith and Noble, 2016). Grant and Booth (2009) identify fourteen different types of review within the health field, including: scoping reviews, rapid reviews, and critical literature reviews. The Grant and Booth (2009) paper was specifically drawn upon as it provided an overview of different approaches to help decide the most appropriate way to conduct a literature review. Within the field of health, Grant and Booth (2009) is widely cited as being rigorous and the standard to use when trying to decide the best approach to conduct a literature review (Mohammed and Ahmed, 2018; Smith and Noble, 2016; Regmi and Gee, 2016).

2.1 First Literature Review

A systematised literature review was chosen for this study as this approach is similar to a systematic review but does not aim for complete comprehensiveness (Clarke and Crane, 2018; Grant and Booth, 2009). A systematised review is a way of synthesising scientific evidence to answer a particular research question in a way that is transparent and reproducible, while seeking to include all published evidence on the topic and appraising the quality of this evidence (Lame, 2019). This approach is considered appropriate for an individual project, such as a postgraduate student assignment (Grant and Booth, 2009). This type of review was chosen over the other thirteen types of review defined by Grant and Booth (2009), because this literature review is a substantial piece of research that aims to identify, select, and synthesise all research published on a particular topic; furthermore, it allowed a range of studies to be included in the first literature review. This approach was critical for the next chapter, as it helped to inform which methodology to utilise to answer the broader research questions, as discussed further in chapter three.

Jahan et al. (2016) propose that the benefit of conducting a systematised literature review is the ability to categorise different types of data on a specific topic. It is a useful approach to review different aspects of a study (such as study designs, data collection methods, and findings) examined by previous researchers, and helps determine the most suitable approach for developing that topic (Snyder, 2019). Systematised literature reviews can also be regularly updated, which is useful for longer-term studies, such as a PhD thesis (Conole, 2002; Paez, 2017; Grant and Booth, 2009). A perceived weakness of this approach is that the quality of individual studies, assessments, and synthesis may be less identifiable (Conole, 2002; Grant and Booth, 2009). The attempt at systematicity is to be welcomed as such reviews do possess a greater likelihood of bias than those that adhere more strictly to guidelines on the conduct of systematic reviews, because it is only conducted by one researcher (Clarke and Crane, 2018). For this thesis, a systematised literature review was considered the best approach.

A systematised review of the related literature was carried out using the Khan et al. (2003) guidelines, which outline five steps. The process followed is: 1) framing the questions for a review; 2) identifying relevant work; 3) assessing the quality of studies; 4) summarising the evidence; and 5) interpreting the findings. This approach was chosen because it was used in previous Public Health research and provided a logical process (Khan et al., 2003; Pullin and Stewart, 2006).

This review focused on the existing body of systematic reviews on this topic because each has collated a wide range of data, has been peer-reviewed and, therefore, will be of a high standard (Mallett et al., 2012). Moreover, this means that the qualitative and quantitative data on my particular topic has

already undergone synthesis and is readily available (Mallett et al., 2012). Grant and Booth (2009) point out that a limitation of only focusing on systematic reviews is the possibility that other relevant studies may be excluded. Nevertheless, this was considered a practical approach to gathering a wide range of literature, and the whole point of the systematic review was that they bring together a range of relevant papers that specifically address the questions for review (discussed below). This approach was specifically chosen in the context of this research because the existing body of literature covers many different studies on spirituality. It also allowed me to incorporate the most rigorous high standard studies, which met the relevant criteria.

2.2 Framing the questions for a review

Particularly within health research, a clearly framed question for the literature review creates the structure and delineates the approach which defines the research objectives for conducting systematic reviews and developing health guidance (Armstrong et al., 2007; Guyatt et al., 2011; Morgan et al., 2016). Research shows that clear, succinctly posed research questions, aims, and outcomes are essential if studies are to be successful (Doody and Bailey, 2016; Morgan et al., 2016; Moule and Goodman, 2014). To ensure an applicable research question was proposed for a literature review, a Population Exposure Outcome (PEO) question was developed. A PEO informs the objectives/outcomes, the study design, and the inclusion and exclusion criteria for a review (Morgan et al., 2018). This approach is widely used in health research because it helps create, manage, and break down research questions (Bettany-Saltikov, 2012).

The PEO question and aim for this literature review was:

Is there an association between adults' spiritual practices and/or beliefs and Public Health outcomes?

This question was developed using a PEO approach. Conducting preliminary reading deepened my understanding of topical debates and issues**,** allowing me to see the research gaps, and decide the specific questions that I wanted to explore within my research. More detail on the PEO question is as follows:

- **Population:** Adults, who are defined as aged 18+, globally. This includes populations of both healthy and unhealthy populations, for example, people with or without an illness.
- **Exposure**: To spiritual beliefs and practices (not religious).
- **Outcomes**: This includes outcomes related to Public Health policy, practice, or specific health outcomes.

In relation to the PEO question, the purpose of the literature review was to enable me to answer the following outcomes:

1. How is spirituality currently defined within Public Health literature?
2. How does the literature treat or frame the relationship between spirituality and Public Health?
3. Which methodologies appear to be most dominant in this area of research?
4. What current validated spiritual tools are used in Public Health?

For this systematised literature review, Public Health was classified as 'the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society' (Acheson, 1988; WHO, 2019). Public Health literature was defined as any literature that directly references the term 'Public Health' outcomes. Examples included those that discuss the impact on people's health, education, or influence policy.

Before the literature review, a concept analysis of spirituality was undertaken, which is discussed in detail in section 2.17.1.1. Spirituality was defined as 'that which seeks to transcend the self and find meaning and purpose; this could be achieved through connection and engagement with others, the surrounding environment or oneself' (Holt, 2016). For this literature review, 'spiritual practices' was viewed as an umbrella term covering many different activities and exercises, such as singing, dancing, yoga, meditation, or Tai Chi. Some scholars argue that spiritual practices are, although not exclusively, methods to engage with spirituality (Oxhandler and Pargament, 2014; Sperry, 2012). People's spiritual beliefs could inform their spiritual practices (Lynch, 2007; Rosmarin and Koenig, 2020). These could be broadly understood as 'spiritual constructs', spiritual beliefs or practices that 'originally derived from religious traditions but, due to their development, can be marginal/multiform spiritual practices' (Oman, 2018, p.48). How these terms were employed when examining the literature is discussed below.

2.3 Identifying relevant research

The literature search strategy was divided into three stages: the first stage involved searching for the appropriate literature. The second stage involved a critical reading and analysis of the articles identified as relevant to this research. Finally, the quality of the selected sources was evaluated.

Timeframe

The search was limited to studies published between 1950 and 2020. As highlighted in chapter one, the existing literature showed the rise of contemporary spirituality as part of the late capitalist cultural shift 'from the collective norms and values that were hegemonic in the 1950s and 1960s, toward a

much more competitive individualism as the central value in an entrepreneurial culture that has penetrated many walks of life' (Harvey, 1989, p.171). The modern use of the term 'spirituality' was first recognised in the 1960s, after the Second World War; an increasing number of people turned to spirituality, rather than religion, as a source of solace and to find sanctuary from the busy consumer world (Hay and Hunt, 2000; Tischler, 1999; Roof, 2001). The literature search end date was December 2020, as this was when the final literature review was conducted as part of the write-up of the final thesis. This chosen time scale was long enough to capture all the significant key studies published in the time period. The definitive literature review was completed in January 2021.

Criteria for Inclusion and Exclusion

In line with the PEO, inclusion and exclusion criteria were developed to help identify and source the most relevant literature. These criteria were developed during the initial phase of this systematised literature review. To ensure that the reviewed articles captured the essence of the research question, papers were included if they:

- Addressed the PEO question (Is there an association between adults' spiritual practices and/or beliefs and Public Health outcomes?) and the four questions/outcomes set out at the beginning of this chapter (on page 50), about the relationship between spirituality and people's health within the context of Public Health.
- Were published in peer-reviewed journals with 'spirituality' appearing as an important factor. This important factor was determined by 'spirituality' being in the title, keywords, or abstract.
- Were systematic reviews.
- Were sourced from international/global sources/publications.
- Were English language publications.
- Referenced adults (defined as 18+) as the participant population.
- Discussed any health conditions.

The exclusion criteria were developed to ensure that any irrelevant articles were excluded, hence, articles were excluded if they met the following criteria:

- They were not systematic reviews.
- They were studies on children, defined as being under 18, due to the focus of my research being on adults.
- Articles that did not mention 'spirituality' in the title, keywords, or abstract. This was important to help narrow down relevant papers and address the PEO and the outcomes of the study. While

using this approach might miss relevant literature, it was deemed the best approach to capture the relevant systemised reviews and address the research question.

- Were from any other disciplines not directly related to Public Health. For example, finance, business studies, chemistry, geosciences, mathematics, English, information technology, or engineering.

To further determine which systematic reviews were included, the focus of the papers was on 'spirituality', as opposed to religion. It is important to note that, when examining the literature, it became apparent there were limited systematic reviews that specifically focused on spirituality without including religion. In some of the systematic reviews identified, the terms religion and spirituality were combined or used interchangeably. Some of these papers were included in the literature review if they helped to address the research question. To deal with this issue, a systematic review was selected on the basis that if spirituality was seen as the main focus of the paper, and religion was a 'lesser part', then they were included. To decide if these combined systematic reviews were included, the 'spiritual element' needed to be presented throughout the research paper and address the literature review outcomes (limitations of this approach are discussed in section 2.7). For example, the Hai et al. (2019) paper 'The efficacy of spiritual/religious interventions for substance use problems: A systematic review and meta-analysis of randomised controlled trials' was included because it discussed spirituality throughout. However, Snider and McPhedran's (2014) paper on 'Religiosity, spirituality, mental health, and mental health treatment outcomes in Australia: A systematic literature review,' was excluded; although spirituality appears in the title, it was not in the abstract, and as stated in the introduction, it focused on religious elements of prayer, church attendance, church affiliation, and belief in God or a higher power.

Online searches

Four academic online search engines were searched to find the literature: CINHAL, Ovid, PubMed, and Science Direct. These were accessed through Canterbury Christ Church University (CCCU) Library Collection. These search engines are considered to cover the most relevant journals that tend to be the standard used within Public Health.

Search terms

To ensure no relevant literature was missed, searches were undertaken using controlled vocabulary derived from the National Library of Medicine's thesaurus (MeSH), which is used in the MEDLINE/PubMed and CINAHL subject headings authority file databases (Baumann, 2016). MeSH terms assist the location of articles that are specifically about a topic, rather than just mentioning it in passing (Baumann, 2016; Coletti and Bleich, 2001). Using this strict regulation resulted in more

efficient searching (Baumann, 2016; Lowe and Barnett, 1994). The MeSH synonyms of 'spirituality' and 'Public Health' (retrieved 1/1/2021) were:

Spirituality: spiritual, faith, mindfulness, religion.
Public Health: health, health promotion, wellbeing.

As these search terms were broad concepts within themselves, few synonyms were required. This approach was useful to help narrow down the search in the index search engines such as PubMed. Initially, the search generated a significant amount of literature which, after examination, proved irrelevant. Therefore, search terms were narrowed down further by excluding 'religion' and 'faith', as the focus was on the spiritual element as distinct from spirituality. 'Health promotion' was also removed from the search terms, as it did not appear to make any difference to the searches. It appeared to bring up the same number of papers addressing Public Health and wellbeing. The search term 'spiritual' helped to bring up literature on both 'spiritual practices' and 'beliefs'. Within the systematised literature search, there was no need to differentiate between these two terms; as long as they were directly related to spirituality, they were relevant to this study.

To help focus on the spiritual element, synonyms of 'Spiritual but Not Religious' or 'SBNR' were included. However, these terms did not come up in MeSH; as a result, an attempt was made to use these same terms in the Oxford Online Thesaurus, the Cambridge Online Thesaurus, and the Macmillan Online Thesaurus, but no results of synonyms appeared here either. Therefore, to find synonyms for SBNR, Mercadante's (2020) article 'Spiritual struggle of 'Nones' and Spiritual but not religious (SBNRs)' was drawn on to present synonyms of SBNR. These synonyms included: 'Spiritual but Not Religious,' 'not affiliated', 'secular', 'atheists', 'agnostics', 'humanists', 'non-religious', and 'Nones' (presented in Table 1). These were the search terms that were used to explore the databases. Mercadante's work was specifically drawn upon, as she is highly renowned in this field of research (Oppenheimer, 2014; Straker, 2019). This particular article has been chosen as it was peer-reviewed and current, thus identifying the appropriate search terms for this study; it also encompasses findings of her previous research. A critique of applying this approach is that other appropriate search terms might be missed. However, this was unlikely, as an attempt was made to examine other research in this field and these synonyms seem consistent in current literature. The term 'systematic review' was also added to ensure the search unearthed the right types of studies. It should be noted that, even when adding the term 'systematic review,' other styles of reviews still appeared in the search results.

The search parameters were set to identify all titles and abstracts containing these terms. Within the search engines, where applicable, a Boolean search term (where special words or symbols can be used to limit, widen, or define a search, such as AND/OR) was used to help widen the search to make sure all relevant literature was captured (Fisher, 2020); this is shown in Table 1. Each database was also further refined to meet the inclusion and exclusion criteria.

2.3.1 Stage one

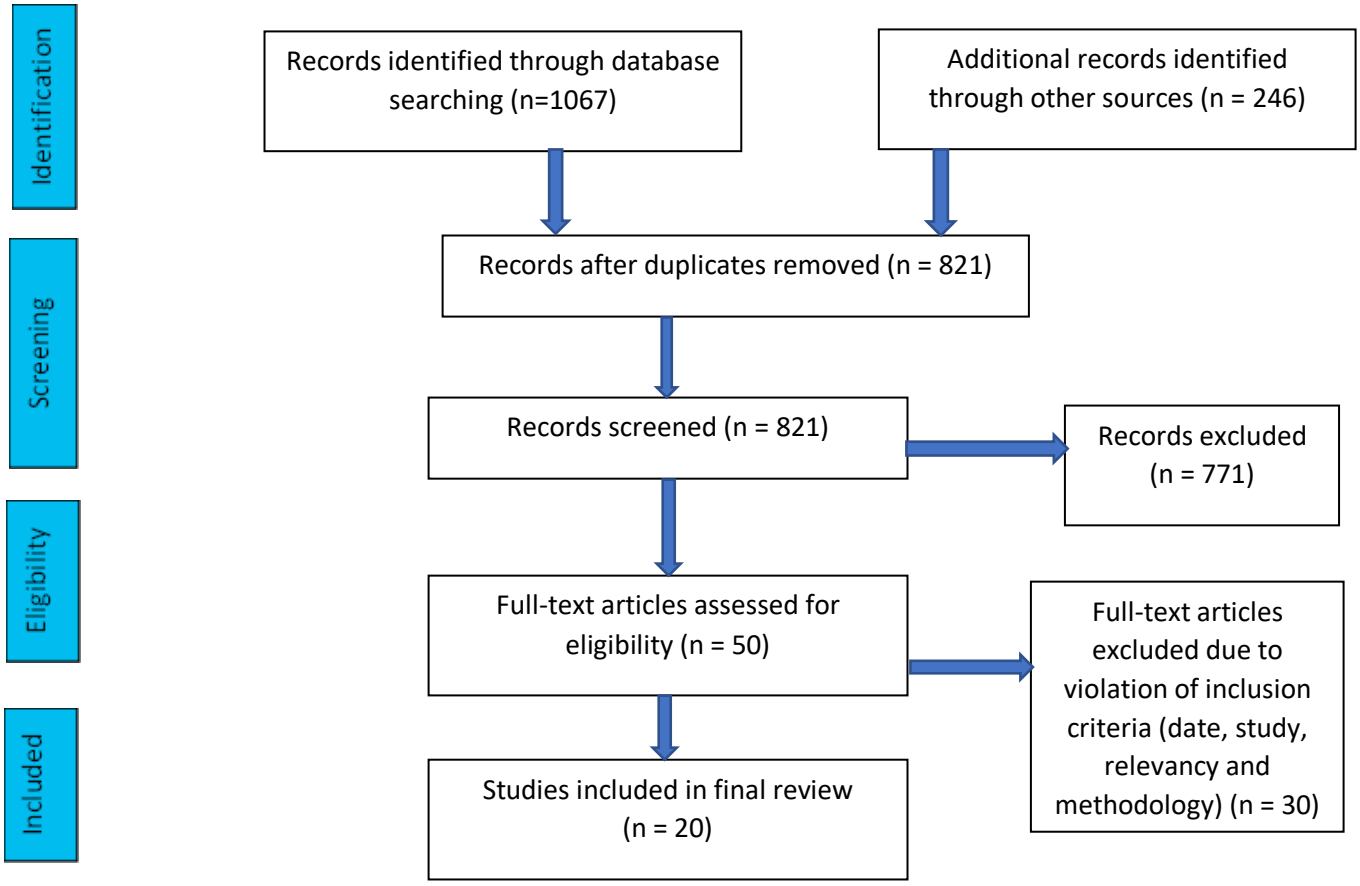
Within the four online search engines identified, using the key terms and refinement year, the search for the relevant literature commenced. Table 1 illustrates the number of sources found in each search engine.

Table 1: Searching for relevant literature

Search engine	Keywords/search string	Date the search was conducted	Paper published Refinement year	Number of sources found
CINHAL	(spirituality OR spiritual OR mindfulness) AND ("Public Health" OR health OR wellbeing) OR ("Spiritual but Not Religious" OR SBNR OR "Not Affiliated" OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones) AND systematic review.	1/1/2021	1950-2020	124
Ovid	(spirituality OR spiritual OR mindfulness) AND ("Public Health" OR health OR wellbeing) OR ("Spiritual but Not Religious" OR SBNR OR "Not Affiliated" OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones) AND systematic review.	1/1/2021	1950-2020	267
PubMed	(spirituality OR spiritual OR mindfulness) AND ("Public Health" OR health OR wellbeing) OR ("Spiritual but Not Religious" OR SBNR OR "Not Affiliated" OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones) AND systematic review.	1/1/2021	1950-2020	106
Science Direct	(spirituality OR spiritual OR mindfulness) AND ("Public Health" OR health OR wellbeing) OR ("Spiritual but Not Religious" OR SBNR OR "Not Affiliated" OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones) AND systematic review.	1/1/2021	1950-2020	628

Initially, 1125 papers were identified from a range of academic peer-reviewed journals, published in English, from around the world. There were 58 papers that were found in more than one of the search engines. This brought the initially identified papers down to 1067 papers. Relevant research studies, scholars, and/or topics recommended by my supervisors and colleagues were also included (n=246). These additional sources are included in Table 2 under 'additional records identified'.

Table 2: Flow diagram of the various phases of the systematised review inspired by Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)



2.3.2 Stage two

After completing the literature search, duplicate articles were removed that arose from the additional records identified (n=246). Following this stage, the titles and abstracts of papers were checked (n=821) and excluded if not in adherence with the inclusion and exclusion criteria (n=771). For example, if their research focus was not in the context of Public Health, they did not meet the criteria. The details of the remaining papers (n=50), which were full-text articles, were then placed into a Microsoft Excel spreadsheet for further investigation. Titles and abstracts were screened for relevance, and the full text of each article was scanned to establish that it met the inclusion criteria, following a review of the 50 studies and excluding all the irrelevant studies (noted in Appendix 2). These papers were excluded on the grounds that they were not systematic reviews (n=22), not peer-reviewed (n=10), and/or not relevant to this research topic (n=7) as they focused more on religion, rather than on spirituality (n=7), while a few included children (n=4).

These exclusions left 20 papers eligible for inclusion in the final analysis (presented in Table 3). All articles that met the inclusion criteria were carefully read, analysed, and any relevant references that met the inclusion criteria were followed up and included in the analysis (Aveyard, 2014; Booth, Sutton and Papaioannou, 2016; Fink, 1998).

2.3.3 Assessing the quality of studies

The body of literature remaining after the completion of the inclusion-exclusion criteria checks was evaluated using the Critical Appraisal Skills Programme (CASP) checklist. The role of CASP was to provide an overview of the good, indifferent, or poor reviews. This approach systematically assesses the trustworthiness, relevance, and results of published papers (CASP, 2020). The CASP checklist for systematic reviews (2018) was used to establish the quality of each review included in this systematic overview. The CASP scoring systems work by having a 'yes', 'no', and 'can't tell' option and scoring each systematic review against the criteria. The scoring range is out of ten. These scores would be used to determine the quality of the paper. Any article which scored above eight was considered of high quality. Table 3 demonstrates the CASP scores of the relevant articles identified in this study.

The CASP checklist was applied because it is renowned as a method for identifying the quality of the papers (Long, French and Brooks, 2020). Noyes et al. (2018) pointed out that a limitation of using this approach is that it relies on the researcher's subjective interpretations. There is broad debate and little consensus among the academic community over what constitutes 'quality' in research (Long, French, and Brooks, 2020). To help resolve this, the CASP tool was devised for use with health-related research and was therefore deemed appropriate for the context of this review (Long, French and

Brooks, 2020). The CASP tool is considered to be a user-friendly option for researchers and is endorsed by Cochrane and the WHO for use to synthesis evidence (Hannes and Macaitis, 2012; Long, French and Brooks, 2020; Noyes et al., 2018).

Table 3: Quality assessment using CASP criteria for systematic studies

Lead author* / CASP questions	1. Did the review address a clearly focused question?	2. Did the authors look for the right type of papers?	3. Do you think all the important, relevant studies were included?	4. Did the review's authors do enough to assess the quality of the included studies?	5. If the results of the review have been combined, was it reasonable to do so?	6. What are the overall results of the review?	7. How precise are the results?	8. Can the results be applied to the local population?	9. Were all important outcomes considered?	10. Are the benefits worth the harms and costs?	Score
Braam	Y	Y	Y	Y	Y	Y	Y	C	Y	Y	9
Gijsberts	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Gonçalves	Y	Y	Y	Y	Y	Y	Y	C	Y	Y	9
Gordon	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Hai	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Hosseini	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Hulett	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	9
Lewis	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	9
Liefbroer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Milner	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Monod	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Moreira	Y	Y	Y	N	Y	Y	Y	N	Y	Y	8
Schreiber	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Selman	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Shaw	Y	Y	C	N	Y	Y	Y	C	Y	Y	7
Smith-MacDonald	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Tate	Y	C	C	N	Y	Y	Y	Y	Y	Y	7
Thune-Boyle	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	9
Wang	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Weaver	Y	Y	Y	N	Y	Y	Y	N	Y	Y	8

* Full list of authors and references can be found in Appendix 3.

Key	Score
Y= Yes	1
N= No	0
C= Cannot tell	0

The assessment was carried out by examining each of the papers and checking that they met each individual CASP criteria (demonstrated in Table 3). From the CASP assessment, out of the twenty systematic reviews, eleven of them fully met the criteria. To give an overall understanding of the quality of the reviews (illustrated in CASP), there are several areas the systematic reviews addressed well. For example, all the reviews scored highly on a 'clearly focused question,' and presented 'clear aims and research outcomes'. The overall results of the reviews were presented clearly. One area in which several of the systematic reviews did not score so highly was when deciding whether the results could be applied to the wider population. These studies tended to focus on specific populations; people who were undergoing cancer treatment for example, or individuals with mental illnesses or specific interventions. To demonstrate this, Gonçalves et al.'s (2017) study entitled Religious and spiritual interventions in mental health care: a systematic review and meta-analysis of randomized controlled clinical trials (RCT), focussed on RCT over the local population, making it challenging to decide whether the results could be applied to the wider population.

The systematic reviews by Shaw, Joseph, and Linley (2005) and Tate (2011) were excluded because it was unclear if they had assessed the quality of the papers or included all the relevant papers in their reviews. Consequently, they did not meet the CASP criteria of eight or above. This left eighteen systematic reviews to be included in the final analysis, which meet the majority of the CASP criteria and can therefore be perceived as high-quality systematised reviews. Not only did they assist with addressing the PEO and outcomes of this review, but they also succeeded in bringing together a wide body of literature. On the other hand, a potential limitation in using these specific papers lies in the possibility that they could have missed other relevant literature or information relevant to this thesis. Nonetheless, these eighteen systematic reviews were considered of high quality because of the factors outlined above.

2.4 Data extraction and analysis

This systematised literature review restricts itself to narrative summaries of the findings. Two tables presented below, were designed to address the PEO and four outcomes (on page 50) and to identify and classify major topics of relevance. A review grid, drawing upon the meta-summary approach illustrated by Aveyard (2014), was developed to gather details of all selected articles (Table 4 and 5). The grid development aimed to present the compiled data in alphabetical and logical order to facilitate comprehension and systemise the articles.

2.5 Summarising the evidence

The data derived from the reviewed studies were placed into two tables. One contained predominantly quantitative data (Table 4), the other focused on more detailed qualitative findings (Table 5). Table 4 includes the name of the first author, the year, the number of studies referenced within each review, the time frame in which the review was conducted, the type and number of participants in total within each review (where stated), where the study was conducted, the types of methods examined in the systematic review, and the nature of the discussed health issue. Table 5 presents the aim of each review, the key findings, recommendations, and a few critiques of each systematic review.

Table 4: Summary of systematic reviews of the descriptive characteristics

First author*	Year	No. of studies referenced within each review	Time frame	Type and No. of participants in total within each review (where stated)	Where study was conducted	Types of methods examined in the systematic review	What sort of health is being discussed
Braam	2019	152	1978-2018	People with depression (n=232,941)	Netherlands	Quantitative Prospective, empirical and RCT	Depression
Gijsberts	2011	39	1980-2009	End of Life (n=5,024)	Netherlands	Quantitative Empirical	End of life
Gonçalves	2017	30	2011-2014	Sick and healthy people (diagnoses included mental health disorders, cancer, chronic diseases, substance use/abuse and cardiac conditions (n= 2,721)	Brazil	Quantitative RCT	Physical health and quality of life
Gordon	2018	26	2004-2005	ICU patients and their surrogates (n=not specified)	USA	Mixed - Methods including quantitative and qualitative studies and mixed methods	Spiritual needs of ICU patients and surrogates
Hai	2019	20	1990-2018	People with substance issues (n=3,700)	USA	Quantitative RCT	Substance use
Hosseini	2019	17	1990-2018	Adult participants aged 18 years or older, regardless of gender or comorbidities, recruited from any healthcare setting (n=35,741)	Canada	Quantitative Comparison group	Cognitive function
Hulett	2016	22	2005-2015	Breast Cancer Survivors (n=2,005)	USA	Quantitative RCT and non-RCT	Breast cancer
Lewis	2008	35	1982-2005	People who identified as African Americans (n=4,618)	USA	Quantitative Any reliant quantitative study	Spiritual measures used in health research

Liefbroer	2017	22	2000-2017	Assess measures of spirituality (n=907)	UK	Qualitative Any reliant qualitative study	Interfaith spiritual care in professional caring relationships
Milner	2020	38	2000-2018	People with mental health difficulties (n=594)	Netherlands	Qualitative Any reliant qualitative study	Mental health
Monod	2011	35	1806-2011	Diverse populations (n=19,173)	Switzerland	Quantitative Any reliant qualitative study	Instruments used in clinical research that measure spirituality
Moreira	2020	9	2011-2017	Adults (n=11,665)	Brazil	Quantitative cross-sectional design	Impact of physical activity on physical and mental health.
Schreiber	2012	18	1985–2010	Women with breast cancer (n=2,613)	USA	Quantitative Any reliant quantitative study	Breast cancer
Selman	2011	38	1806-2010	People with cancer, Human Immunodeficiency Virus (HIV), or experiencing palliative care populations (n=not specified)	UK	Quantitative and Qualitative Any reliant quantitative or qualitative study	Cancer, HIV, or palliative care populations
Smith-MacDonald	2017	43	0** - 2016	Veterans (n=22,854)	Canada	Quantitative (n=37) Qualitative (n=5) Mixed methods (n=1)	Mental wellbeing in post-deployment veterans
Thune-Boyle	2006	17	1977–2004	Cancer patients (n=4,993)	UK	Quantitative Any reliant quantitative study	Cancer
Wang	2017	8	0** - 2016	People with terminal and advanced cancer (n=955)	Hong Kong	Quantitative RCT	Terminal and advanced cancer
Weaver	2003	469	1990-1999	Not specified	USA	Quantitative and Qualitative Any reliant quantitative or qualitative study	Trauma

* The full list of authors and references can be found in Appendix 3.

** These articles in the search criteria did not have a start date.

Table 5: Summary of systematic reviews key findings

First author*	Aim of review	Key findings	Future recommendations	Critique
Braam	To identify patterns in the relationship between religion/spirituality (R/S) and depression over time.	In half of the studies, R/S predicted a significant but modest decrease in depression over time. In 49% of the studies, spirituality decreases in depression over time. Among persons with psychiatric symptoms, spirituality tended to be more protective. Among persons with physical illnesses, religiosity tended to be less protective.	Further enquiry into bi-directional associations between religious and spiritual struggle and (clinical) depression over time seems warranted.	Strengths Provides new insights and a systematic review on depression. Limitations Geographical differences in the findings were not present. There is a large heterogeneity of studies (samples size, duration of follow-up), the current synthesis of evidence is only exploratory. Not always focused on spiritual studies.
Gijsberts	To conceptualise spirituality by identifying dimensions, based on instruments measuring spirituality in end-of-life populations.	Instruments measuring spirituality that are currently being used in end-of-life situations resulted in a comprehensive model conceptualising spirituality and distinguishing three dimensions of spirituality and their associations.	To test the model for the conceptualisation of spirituality at the end-of-life model in practice.	Strengths Conceptualisation of measurable aspects in end-of-life care. Providing a more balanced review of aspects relevant to spirituality at the end of life. Limitations Findings are based on other studies.
Gonçalves	To examine whether religious and spiritual interventions (RSIs) can promote physical health and quality of life in individuals.	Clinical trials on RSIs demonstrated that they had small benefits compared with other complementary health therapies by reducing pain and weight, improving quality of life and promoting health behaviours. The lack of clinical trials that included biological outcomes and the diversity of approaches indicate a need for more studies to understand the possible mechanisms of action of RSIs and their roles in healthcare.	Further investigation in this area is imperative to better understand the mechanisms behind RSIs.	Strengths Revealed how religious and spiritual interventions (RSIs) can promote physical health and quality of life in individuals. Robust study. Limitations The inability to perform a meta-analysis was due to the heterogeneous protocols and outcomes reported in each selected study. Exclusion of studies that investigated ancient practices and philosophies, due to the specific characteristics of their approach, which follow a pre-determined concept and were previously discussed elsewhere.
Gordon	To provide an overview of research on spirituality and religiosity in the intensive care setting (ICT) that has been published since 2004–2005.	Spiritual care has an essential role in the treatment of critically ill patients and families. Chaplains are specialists, and clinicians are generalists regarding spiritual care. Current literature offers few insights to support clinicians in navigating this often a challenging aspect of patient care.	Further studies may involve assessing the frequency of such consult requests from patients and families, the frequency of chaplain visits, and patient and family feedback regarding satisfaction of how spiritual needs were addressed in the ICU.	Strengths Identified ways to address these needs. Additional research is needed to understand the impact of optimised methods of addressing spiritual and religious needs in the intensive care setting of interest. Limitations It has challenges in describing and measuring spirituality and religiosity.
Hai	To examine the efficacy of S/R interventions in reducing substance use and enhancing participants' psycho-social-spiritual wellbeing.	S/R interventions' efficacy in helping people with substance use problems. Most RCTs have focused on 12-step-oriented interventions, while RCTs on non-12-step-oriented S/R interventions are scant. Of the interventions studied, 12-step-oriented interventions were more efficacious than non-S/R comparison interventions for people with substance use problems.	More high-quality efficacy studies of non-12-step-oriented S/R interventions for substance use problems are needed.	Strengths Comprehensive and systematic search and screening methods were employed. Findings supporting S/R interventions' efficacy do not imply that the S/R mechanism is the only mechanism operating or that it is operating at all. Limitations

				Excluding non-RCT studies and studies that failed to report sufficient effect size data limited the evidence gathered for this review and neglected potentially valuable information that studies with other research designs may provide. Weakness is inherent in the quantitative meta-analytic approach used in the current review. RCTs are deemed the most rigorous research designs. Therefore, results are based on the best quantitative evidence regarding S/R interventions' efficacy. - Effect size estimates were aggregated on the generic construct level (substance use outcomes and psycho-social-spiritual outcomes) rather than on specific measures, despite the diverse measures used in the primary studies for each outcome construct. - Only examines the efficacy of S/R interventions and not the mechanisms through which S/R interventions exert their effects due to limited information provided in the primary studies.
Hosseini	To investigate the association between religious/spiritual involvement (R/SI) and cognitive function in adults of any age and any setting.	R/SI appears to be protective against cognitive decline in middle and old age adults. The majority of studies reported statistically significant findings regarding the positive association between the exposure and outcome. Public Health practitioners should not overlook the benefits of enabling religious/spiritual practices among religious adults. The practices included any activity that promotes an active, stimulating and socially engaged lifestyle that preserves healthy cognitive function, such as spiritual/religious books or going to church/place of worship.	Recruit individuals from the entire adult life span, examine the association in different religious denominations, and include longer follow-up periods.	<u>Strengths</u> Provides knowledge on the association between R/SI and cognitive function. <u>Limitations</u> Not able to conduct a meta-analysis. Lack of information on younger and non-Christian groups, a dearth of long-term follow-up data, and little evidence regarding whether R/SI has an effect over and above social engagement. No measure of spirituality or religiosity from the cohort was available prior to age 79 years and no measure of religious belief was available earlier than age 83 years.
Hulett	To review psycho-neuroimmunological-based interventions (PNI) for health outcomes associated with religious and spiritual-based interventions in breast cancer survivors.	A positive pattern of relationships between spiritual-based interventions, mental health outcomes, and neuroendocrine-immune function in breast cancer survivors. Few spiritual-based interventions specifically measure religious or spiritual constructs. Similarly, few existing studies utilise standardised religious or spiritual measures with PNI outcome measures. Findings suggest that a body of knowledge now exists in support of interventions with mindfulness-breathing-stretching components; furthermore, these interventions appear to offer potential improvement or stabilisation of neuroendocrine-immune activity in breast cancer survivors compared to control groups. Future spiritual-based interventions should include standardised measures of religiousness and spirituality to understand relationships between and among religiousness, spirituality, and neuroendocrine-immune outcomes.	Focus on determining the minimum dose and duration needed to improve or stabilise neuroendocrine-immune function, as well as diverse setting needs, including home-based practice for survivors who are too ill to travel to group sessions or lack economic resources.	<u>Strengths</u> Provides insight into spiritual-based Interventions in breast cancer survivors. <u>Limitations</u> This design does not allow for individual differences in psychosocial-spiritual variables. For example, perceptions of distress, spiritual beliefs, coping skills, and lifestyle behaviour patterns. This review did not utilise a standard measure of study quality as this was beyond the focus of the review. Rigour of study randomisation and blinding practices were not examined.
Lewis	To evaluate the construct validity and reliability of spirituality measures used in	Spirituality is a significant cultural experience and belief that influences the health behaviours of African Americans.	The development of a more appropriate measure of spirituality may be warranted to enhance study in spirituality and health research.	<u>Strengths</u> Provides insights concerning the assessment of spirituality in African Americans in a culturally appropriate manner.

	health research from 1982 to 2005.	The lack of a culturally appropriate measure of African Americans' spirituality is a major limitation of studies investigating spirituality and health in this population.		Identified a gap in the literature to the psychometric evaluation of spirituality measures in completely African American samples. Limitations Several measures of spirituality were not able to be reviewed because psychometric data was not available for published studies investigating spirituality and health.
Liefbroer	The objective of this review was to provide an overview of recurring themes in the empirical literature on interfaith spiritual care (ISC) in a professional, caring relationship.	Spirituality plays a role in the lives of many people who experience mental health difficulties. It indicated the importance of mental health professionals being aware of and prepared to support the spiritual dimension of people using services. The production of a theory-based framework can inform efforts by health providers to understand and address people's spiritual needs as part of an integrated, holistic approach towards care.	Explore patients' perspectives on ISC, to learn how ISC contributes to patients' spiritual wellbeing.	Strengths Identifies some key issues in interfaith spiritual care (ISC) within a landscape characterised by a diversity of spiritual needs. It provides an overview of what is known regarding ISC and identifies gaps in the literature. Limitations Mainly focused on professional caregivers' perceptions, and only five of them have examined clients or patients' perspectives. The number of empirical studies identified is small (twenty-two), and the data gathered in these studies are limited because of small sample sizes.
Milner	To characterise the experiences of spirituality among adults with mental health difficulties in published qualitative research.	Despite an increasing awareness of the importance of spirituality in mental health contexts, a 'religiosity gap' exists in the difference in the value placed on spirituality and religion by professionals compared with service users. This may be due to a lack of understanding about the complex ways people connect with spirituality within contemporary society and mental health contexts, and can result in people's spiritual needs being neglected, dismissed or pathologised within clinical practice. This systematic qualitative review provides evidence of the significant role spirituality plays in the lives of many people who experience mental health difficulties. It indicated the importance of mental health professionals being aware of and prepared to support the spiritual dimension of people using services. The production of a theory-based framework can inform efforts by health providers to understand and address people's spiritual needs as part of an integrated holistic approach towards care.	To further refine the framework's applicability in clinical and training contexts and to create clear guidelines for this.	Strengths Presents the experiences of spirituality among adults with mental health difficulties. Provides evidence of the significant role spirituality plays in the lives of many people who experience mental health difficulties. It indicated the importance of mental health professionals being aware of and prepared to support the spiritual dimension of people using services. Provides new and important evidence about experiences of mental health and spirituality in a way in which is difficult with individual small-scale qualitative studies. It spans a range of countries, cultures, religious and spiritual beliefs systems and mental health diagnoses, thus providing a diversity of contexts that contribute to the transferability and rigour of the findings. Limitations Issues over decontextualising findings.
Monod	To identify instruments used in clinical research that measure spirituality; to propose a classification of these instruments; and to identify those instruments that could provide information on the need for spiritual intervention.	Instruments identified in this systematic review assess multiple dimensions of spirituality, and the proposed classifications should help clinical researchers interested in investigating the complex relationship between spirituality and health. Findings underscore the scarcity of instruments specifically designed to measure a patient's current spiritual state.	Determine the level of change that would be considered meaningful and accurately assess the effectiveness of interventions to improve a patient's spiritual state.	Strengths Complemented with input from experts in the field. --The proposed functional classification was validated based on the triple-abstraction process that was performed through blind review, with very good agreement observed. Not limited to English-language instruments, but also included some measures developed in French, German and Korea. Limitations Some of the instruments originating from psychological and theological research were not specifically designed for use in clinical studies with health outcomes.

Moreira	To identify in the literature evidence about the effects of the association between spirituality, religiosity, and physical activity on physical and mental health.	The association between spirituality, religiosity, and physical activity promotes effects on physical and mental health. However, the available evidence is not sufficient for this association to be applied in clinical practice.	Better scientific evidence about the effectiveness of the association in question, especially in Latin America and the Caribbean, considering that no studies from these regions were found, which, because they have greater geographical, cultural, and social proximity to Brazil, could corroborate the discussion.	<u>Strengths</u> Discovered that an association between spirituality, religiosity, and physical activity generates effects on physical and mental health. These depend on social and cultural factors of different types of spiritual practices and physical activity. <u>Limitations</u> Limited number of studies with robust methodology in the design. The research of these studies was limited to three languages and the peer-reviewed literature, therefore, other languages and unpublished data, theses, dissertations, and documents of institutional property were not included. The evidence found is insufficient and does not describe the strategies employed, making it impossible to incorporate this association by nurses and other health professionals in their clinical practice.
Schreiber	To critically analyse and synthesise the relationships between psychological wellbeing, religion, and spirituality among women with breast cancer.	There is limited research on women with breast cancer regarding the relationships between religion, spirituality, and psychological wellbeing. There appears to be sufficient evidence to include a brief, clinically focused assessment of women diagnosed with breast cancer regarding the importance of a given belief system as they face the diagnosis and treatment of their disease.	Further investigation of negative religious coping (struggle) and its effect on psychological wellbeing over time is important to understand the short-term or long-term impact of an individual's health-related existential/spiritual crisis on psychological wellbeing and distress.	<u>Strengths</u> Studies reviewed that focused on the concept of spirituality describe spirituality without reference to God or specific religious practices. It highlights the benefits of spirituality and psychological wellbeing among breast cancer survivors. <u>Limitations</u> Limits on ability to generalise the findings of this study.
Selman	To identify and categorise spiritual outcome measures validated in advanced cancer, HIV, or palliative care populations; to assess the tools' cross-cultural applicability; and for those measures validated cross-culturally, to determine and categorise the concepts used to measure spirituality.	The nine tools identified in this review are those that have currently been validated in cross-cultural palliative care populations and, subject to an appraisal of their psychometric properties, may be suitable for cross-cultural research. Despite the need to assess spiritual outcomes in palliative care, little is known about the properties of the tools currently used to do so. Measures of spirituality have been criticised in the literature for cultural bias, and it is unclear which tools have been validated cross-culturally.	To explore, compare, and evaluate the psychometric properties of identified instruments against established quality criteria. To validate existing functional and substantive measures of spirituality in palliative care populations. Focus on adapting and testing the reliability and validity of existing tools in diverse cultural contexts, rather than developing more similar tools. To test the broader conceptual frameworks underlying measures of spirituality, the quantitative exploration of convergence is needed. Further conceptualisations of spirituality would provide valuable data to further elaborate and test the conceptual model.	<u>Strengths</u> Presents measures of spirituality in palliative care. The nine tools identified may be suitable for cross-cultural research. <u>Limitations</u> Criterion of cross-cultural applicability used in this study uses ethnic diversity as a proxy for cultural diversity. Issues over how ethnicity is defined and used in different contexts.
Smith-MacDonald	To examine the relationship between spirituality and mental wellbeing in post-deployment veterans.	There was preliminary low-medium quality evidence for the relationship between spirituality on PTSD, suicide, depression, quality of life, anger, anxiety, and mental health in veterans. Spirituality is a multifaceted construct that may have an important role in supporting and facilitating healing and mental wellbeing in veterans.	The need for robust evidence, which requires future spirituality research to use RCTs and longitudinal designs that will help to identify key time points	<u>Strengths</u> Provides insights into veterans' spiritual wellbeing which should be a routine and integrated component of veterans' health, with regular assessment and treatment.

			where spiritual interventions are most needed for veterans.	Limitations Methodological weakness.
Thune-Boyle	To examine the use of religious/spiritual cognitions and behaviours as coping strategies during cancer, and its effects on illness adjustment, psychological wellbeing, and/or quality of life.	Several studies found non-significant results; an equal number had positive findings showing religious/spiritual coping to be advantageous to illness adjustment during cancer. Only three studies found detrimental effects, two from sub-samples and one study examining negative religious coping, which expects the outcome to be negative. None of the four European studies found religious coping to be important and one even found it to be a disadvantage.	To take a multidimensional approach and examine both positive and potentially negative spiritual and religious coping strategies with specific cancers.	Strengths Identifies spiritual coping strategies. Examines the potential beneficial or harmful effects of religious/ spiritual coping with cancer. Found spiritual coping may also serve multiple functions in long-term adjustment to cancer. Limitations Failed to control for possible influential variables such as stage of illness and perceived social support. Cross-sectional and used mixed cancer groups at different stages of their illness.
Wang	To evaluate the effects of therapeutic life review on spiritual wellbeing, psychological distress, and quality of life (QOL) in patients with terminal or advanced cancer.	Therapeutic life review is potentially beneficial for people near the end of life. Spirituality may help to improve the quality of end-of-life care for individuals facing death, and to support the patients and their families in the best way, by the symptomatic relief of stress, but also for the prevention of distress, promotion of wellbeing, and establishment of a sense of personal meaning and life purpose. It may be necessary to promote therapeutic life review as a palliative care approach and integrate it into end-of-life care practice to enhance the psycho-spiritual wellbeing of terminally ill patients. The results should be interpreted with caution due to the limited number of randomised controlled trials and associated methodological weaknesses.	Conduct more rigorously designed randomised controlled trials on psychological distress, and quality of life (QOL).	Strengths Provides high-quality cumulative evidence from clinical trials that therapeutic life review interventions are potentially effective in facilitating a sense of life meaning, alleviating psycho-existential suffering, and improving QOL for terminally ill patients. Limitations The effects of different dosages and intensity of the interventions and the effects of different strategies were not differentiated due to the limited number of the included trials. Remains unclear about the optimal time to deliver the interventions.
Weaver	To evaluate how frequently issues associated with R/S were discussed in articles published in the Journal of Traumatic Stress in the 1990s.	Analysis of variance found a significant overall increase in the percentage of articles that mentioned R/S between the first half (1990–1994) and the second half (1995–1999) of the study period.	Research is needed to understand the role of a religious community and spiritual practices among refugees, especially since these groups report that their faith involvement is a strong protective factor against distress. Research is needed to better understand the role of R/S for ethnic minority survivors of traumatic events.	Strengths Illustrates R/S are highly valuable to many people in times of crisis, trauma, and grief. Limitations Not always focused on spiritual studies. Only one qualitative study was identified.

***** The full list of authors and references can be found in Appendix 3.

A total of 913 papers were included within the analysed reviews, with a total of 350,504 participants in all the studies included in the systematic reviews (illustrated in Table 5). Each systematic review had over 500 participants within the papers selected. Three systematic reviews did not specify the number of participants: Gordon et al. (2018), Selman et al. (2011) and Weaver et al. (2003). All the reviews were published after 2003, with the majority (15 out of 20) published between 2010 and 2020, indicating a large increase compared with the period preceding 2010. The highest number of papers published in a year was five, in 2011. Most of the studies included papers from over a twenty-year timespan (1998-2018).

Six of the systematic reviews were conducted in the USA, three in the Netherlands, three in the UK, two in Brazil and Canada, one in Hong Kong, and one in Switzerland. Many of the systematic reviews did not specify the country in which the study was conducted in their analysis. The focus of these systematic reviews can be broadly divided into five categories: life-threatening illness (n=7), mental health issues (n=5), spiritual measures (n=4), spiritual care (n=1), and physical health improvements (n=1).

2.6 Interpreting the findings

This systematised review of systematic reviews allowed for the creation of a summary of reviews within a single document. This review seeks to provide insight into the association between adults' spiritual beliefs or practices and Public Health outcomes. To address the four outcomes at the beginning of the literature review (on page 50), the discussion was organised into four sections: 2.6.1 how spirituality is currently being operationalised in Public Health literature; 2.6.2 how the literature treats or frames the relationship between spirituality and Public Health; 2.6.3 which methodologies appear to be most dominant in this area of research; and 2.6.4 what currently validated spiritual tools are used in Public Health.

2.6.1 How spirituality is being operationalised in Public Health literature

There appears to be much confusion over how spirituality is currently being operationalised in Public Health literature. To illustrate how spirituality is operationalised within the literature, to address outcome one, the next section presents four main points: 2.6.1.1 the overlap between the definition of spirituality and religion; 2.6.1.2 separating spiritual and religious literature; 2.6.1.3 the variation over what is encompassed when conceptualising spirituality; and 2.6.1.4 the cultural differences in the meanings attached to the concept of spirituality.

2.6.1.1 Overlap between the definition of spirituality and religion

A fundamental issue of current literature relates to the terms spirituality and religion, which are treated as both interchangeable yet divergent concepts (Table 6 notes which systematic reviews combined the terms spirituality and religion). To explain how they are treated and considered the same term, Hai et al. (2019) recognised that spirituality and religiosity are both multidimensional constructs that can include behavioural, cognitive, existential, ritualistic, and social components. Despite this, the concepts have been viewed separately in other examples of literature, such as Hulett and Armer's study (2016, p.406), which defines spirituality as a 'subjective experience of the sacred', referring to 'an emotional connectedness or relationship with God or the transcendent beyond the self'. On the other hand, 'religion was defined as 'culturally-based practices such as prayer, church attendance, meditation, or reading religious texts.' The separation of spirituality and religion here demonstrates the lack of constancy and variation when defining and measuring these two terms in scholarship.

On the other hand, in some examples of the reviewed literature, the terms 'spirituality' and 'religion/religious/religiosity' were often used as interchangeable synonyms (Hai et al., 2019), a trend, which, was not recognised as an issue. However, this lack of separation can make it difficult to clearly identify the affect specific spiritual elements can have on health. This difficulty has further increased with the added societal shift to secular communities, whereby fewer people now identify as religious (Lewis, 2008; Miller and Thoresen, 2003). The authors of the systematic reviews perceive the terms 'spirituality' and 'religion' as overlapping and interchangeable synonyms are plausible explanations as to why there is a lack of clarity regarding definitions. Indeed, Lewis (2008, p.459) argues that spirituality has often been used 'interchangeably with religion in much of social science and health research, and there is a failure to define the two constructs consistently, clearly, and conceptually' (Miller and Thoresen, 2003; Moberg, 2002). Although there are overlaps between them, 'religion is generally viewed as more community-focused, formal, observable, and objective'; whereas 'spirituality is viewed as individualistic, less visible, more subjective, less formal, and emotionally oriented' (Lewis, 2008, p.459). This separation may become wider and lead to further ways to distinguish the concepts (Lewis, 2008; Miller and Thoresen, 2003). Within health research, this could affect which variables are being measured, thus affecting the results of different studies, hence one reason why some studies report having greater effects than others.

It is important to note that the meanings of these words continue to evolve, with concepts of religion tending to become narrower over time, whereas those of spirituality tend to broaden (Miller and

Thoresen, 2003). In this light, I argue that while these constructs may overlap in common usage, they can, as the literature has demonstrated, develop significantly different meanings. Future research might benefit from taking a singular focus on both spirituality or religion, which would resolve some of these underlying issues.

2.6.1.2 Separating spiritual and religious literature

In order to specifically focus on spirituality, particularly spiritual elements in relation to health, an attempt was made in this study to separate the 'religious' and 'spiritual' aspects of the literature into different elements. This thesis uses Hulett and Armer's (2016) systematic review to separate 'spirituality' and 'religion', and was specifically drawn upon due to it being one of the only papers that had clearly divided spirituality and religion into distinct constructs, which assists with separating spirituality and religion within the current literature. Within their systematic reviews, elements of spirituality and religion were classified by grouping spiritual elements as a 'subjective experience of the sacred' which 'refers to an emotional connectedness or relationship with God or the transcendent beyond the self'. Religious elements, on the other hand, were grouped as 'culturally based practices such as prayer, church attendance, or reading religious texts' (Hulett and Armer, 2016). Although the term 'God' is mentioned in this definition of spirituality, the systematic review separates the idiom as a different entity.

Further systematic reviews attempted to define the concepts as separate entities, such as Lewis (2008), who defined spirituality as 'individualistic, less visible, more subjective, less formal, and emotionally oriented,' and religion as a 'more community-focused, formal, observable and objective' (Lewis, 2008, p.459). Ultimately, Hulett and Armer's (2016) definitions were chosen over Lewis' (2008) as they placed the definitions as relatively distinct constructs. However, the distinguishment between religion and spirituality made it difficult to separate concepts such as 'spiritual coping.' In the contexts to which the paper was applying the term, in order to decide whether the journal articles were spiritual or religious, reasonable judgements were made in line with Hulett and Armer's (2016) definitions in regard to specific findings aligned the best with this systematic review.

2.6.1.3 Variation over what is encompassed when conceptualising spirituality

There is variation over how spirituality is understood within the literature examined. Several of the systematic reviews explored the definitions of spirituality; however, some did not commit to a singular definition within their research. In the literature reviews identified thirteen of the systematic reviews combined the terms, three did not and two of the papers defined separate as separate constructs but

presented the results as one variable. Table 6 illustrates the definitions of spirituality obtained from each systematic review.

Table 6: Definitions of spirituality in the systematic literature review

First author*	Definition of spirituality and religion combined or separate	Definition of spirituality
Braam	Combined	No specific definition.
Gijsberts	Combined	No specific definition.
Gonçalves	Combined	No specific definition.
Gordon	Combined	No specific definition.
Hai	Combined	The universal and fundamental human quality of searching for meaning, wellbeing, and profundity through connections with oneself, others, and the universe, and religion as an institutionalised system of beliefs, values, and practices oriented towards spiritual concerns and transmitted over time by a community.
Hosseini	Combined	No specific definition.
Hulett	Defined separate as separate constructs but presented the results as one variable	A subjective experience of the sacred which refers to an emotional connectedness or relationship with God or the transcendent beyond the self.
Lewis	Defined separate as separate constructs but presented the results as one variable	Individualistic, less visible, more subjective, less formal, and emotionally oriented.
Liefbroer	Combined	No specific definition.
Milner	Separate	Transcend ordinary physical limits of time and space, matter, and energy.
Monod	Separate	A sense of transcendence beyond one's immediate circumstances, and other dimensions such as purpose and meaning in life, reliance on inner resources, and a sense of purpose and life satisfaction.
Moreira	Separate	The attribution of meanings to life, which is not synonymous with religious doctrine, can be considered as a philosophy of the individual and a resource of hope.
Schreiber	Combined	Meaning in life, spiritual wellbeing, and spiritual integration.
Selman	Combined	Beliefs, values, and practices that relate to the search for existential meaning, purpose, or transcendence, which may or may not include belief in a higher power.
Smith-MacDonald	Combined	Beliefs, values, behaviours, and experiences related to ultimate meaning, often involving deities and dogma formulated by faith groups or institutions over time.
Thune-Boyle	Combined	No specific definition.
Wang	Combined	No specific definition.
Weaver	Combined	No specific definition.

* The full list of authors and references can be found in Appendix 3.

As illustrated in Table 6, half of the systematic reviews lacked a clear operational definition of spirituality that was framed in their studies, as they only discussed previous research definitions. To illustrate this point, Gijsberts et al. (2011, p.852) explored definitions of spirituality by Daaleman et al. (2004), Puchalski et al. (2009) and Steinhauser et al. (2006) in their introduction, yet did not state which definition they employed. This was also the case in Braam and Koenig's (2019) and Monod et al.'s (2011) systematic reviews. From these findings, it was unclear what exactly was being measured and included within the definitions, making it a challenge to understand what elements of spirituality

were being explored; this could have impacted how spirituality is perceived to be affecting people's health.

Although there is diversity in meaning and, by default, a lack of commitment to a singular definition, in those systematic reviews where a definition of spirituality was offered words with apparently similar meanings appeared. These included the words 'transcendence' (Hulett and Armer, 2016; Milner et al., 2020; Selman et al., 2011), 'connection' (Hai et al., 2019; Hulett and Armer, 2016), and 'beliefs' (Hai et al., 2019; Selman et al., 2011; Smith-MacDonald et al., 2017). Despite these similarities, the absence of clarification regarding the definition makes it vital to define 'spirituality' in future research.

2.6.1.4 Cultural differences in the meanings attached to the concept of spirituality

The systematic reviews reveal that the research conducted on spiritual beliefs and practices was predominantly undertaken in the USA (Braam and Koenig, 2019; Hai et al., 2019; Thune-Boyle et al., 2006; Schreiber and Brockopp, 2012; Smith-McDonald et al., 2017). Six of the systematic reviews were carried out in the USA; three in the Netherlands; three in the UK; two in Brazil and Canada; one in Hong Kong, and one in Switzerland. The conclusions reached within these papers varied across countries; for example, Hai et al. (2019) findings revealed that spiritual and religious interventions in Canada were less efficacious than other non-spiritual interventions in promoting or supporting good health, whereas the reverse was true in the USA and the Middle East (Hai et al., 2019). This difference highlights an important variation within the studies presented. Thus, Public Health researchers should be mindful of the potential moderating effects of the social and cultural environments when spirituality and religion are being analysed.

Most of the studies incorporated in the systematic reviews recruited participants from faith-based communities, introducing an implicit bias to the data (Braam and Koenig, 2019). Moreover, there appeared to be a dominance of research from the USA, raising questions around bias, as parts of the USA are known to be deeply Christian and conservative. In contrast, the UK could be considered culturally more diverse, particularly in terms of people's beliefs. Arguably the populations of these two nations hold different attitudes concerning spiritual beliefs (Braam and Koenig, 2019; Holloway et al., 2011; Miller and Thoresen, 2003), which are prominent within the literature results. Due to the fact that the majority of the literature originates in the USA, these findings provide a plausible explanation as to why the terms religion and spirituality are used interchangeably in much of the relevant studies; crucially, spirituality and religion are often understood as overlapping constructs in the USA.

2.6.1.5 Summary

The study has thus far demonstrated the principal query of outcome one: the ways in which spirituality is operationalised in Public Health literature. The previous literature review evidences a degree of imprecision over what is encompassed when defining and operationalising spirituality. Confoundingly, spirituality and religion were often viewed as distinguishable yet overlapping concepts. Additionally, according to many of the systematic reviews, there did not appear to be any differentiation between spiritual and religious variables when analysing and presenting the results. Much of the research within the systematic reviews came from the USA and, arguably, their population holds different attitudes compared with the UK population concerning personal beliefs (Braam and Koenig, 2019; Holloway et al., 2011; Miller and Thoresen, 2003). Consequently, it is crucial that Public Health move away from religious language to a more openly post-modern and holistic approach to health (Furman et al., 2005).

2.6.2 How the literature treats or frames the relationship between spirituality and Public Health

This section discusses how the extant literature treats the relationship between spirituality and Public Health. This is presented in the following three sections: 2.6.2.1 the literature was predominantly focused on individuals experiencing ill-health; 2.6.2.2 spirituality can have a positive effect on aspects of people's health; and 2.6.2.3 the literature concentrates on specific facets of health. As discussed in the previous section, separating spirituality and religion was difficult; there has been an attempt to separate the elements of spirituality and religion as much as possible in order to focus on how spirituality has an association with health. However, it is important to note, that at times, they are treated as overlapping constructs.

2.6.2.1 Individuals experiencing ill-health

The systematic reviews mainly focused on individuals who were, at the time of the study, experiencing poor health, such as those living with cancer (Hulett and Armer, 2016; Schreiber and Brockopp, 2012; Thune-Boyle et al., 2006), HIV (Selman et al., 2011), severe mental health issues (Braam and Koenig, 2019), substance issues (Hai et al., 2019), or receiving end of life care treatment (Gijsberts et al., 2011). The findings of the systematic review showed how spirituality was a coping factor for 'wellness' (Hulett and Armer, 2016; Schreiber and Brockopp, 2012; Wang, Chow and Chan, 2017; Weaver et al., 2003), and provided a sense of support for those who were suffering from an illness (Braam and Koenig, 2019); spirituality was also a strong protective factor against distress (Weaver et al., 2003). These findings revealed that people experiencing poor health and life-threatening illnesses can use

spirituality as a coping mechanism. In the broader scope of Public Health, the literature treats spirituality as a means to help ill people to cope with illness and provide a sense of support, and it was a strong protective factor in terms of health outcomes.

Spiritual care was shown to be of benefit in a healthcare setting for those with ill health. Gordon et al. (2018) revealed that spiritual care plays an essential role in the treatment of critically ill patients and their families/carers by providing a sense of support; it was a factor that gave people hope and brought them closer together. This was further supported by Selman et al. (2011), who found that for the participants in their study who lived with cancer, HIV, or experienced palliative care, their concept of spirituality provided valuable tools to help them cope with ill health. Although there is a need for further research, these initial findings reveal the important role spirituality can play for individuals experiencing poor health.

2.6.2.2 Spirituality can have a positive effect on aspects of people's health

The second outcome of this systematised literature review discovered there are elements of spirituality that can contribute to positive outcomes for aspects of people's health. The positive outcomes included improving physical health by reducing pain and weight, improving quality of life, and promoting positive health behaviours (Gonçalves et al., 2017; Moreira et al., 2020). There has also been a considerable number of studies that focused on people who experienced difficult life events and the role spirituality plays in supporting them, by motivating them and enabling a sense of purpose to make a positive lifestyle change (Braam and Koenig, 2019; Weaver et al., 2003). However, a limitation of these studies is that they do not note the precise mechanisms of spirituality that are affecting health, nor the extent to which they affect health.

In relation to mental health, spiritual beliefs were shown to help people cope with and provide resilience against illness, such as cancer (Schreiber and Brockopp, 2012; Thune-Boyle et al., 2006), to support people overcoming substance misuse issues (Hai et al., 2019), and to protect against cognitive decline (Hosseini, Chaurasia and Oremus, 2019), as well as manage anxiety and stress (Braam and Koenig, 2019). In addition, research shows a positive relationship between spirituality and health, as it was demonstrated to assist people with PTSD, suicide, depression, poor quality of life, anger, anxiety, and partially mental ill-health in veterans (Smith-MacDonald et al., 2017). Again, this positive relationship was due to spirituality being used as a coping mechanism in difficult times. These findings were also supported by Hulett and Armer (2016), who discovered a positive pattern of relationships between spiritual-based interventions, mental health outcomes, and neuroendocrine-immune function in breast cancer survivors. Wang, Chow, and Chan (2017) noticed favourable effects of

Therapeutic Life Review (which is the intention of resolving and integrating past conflicts, thus giving new significance to an individual's life, and bringing peace to the individual) on spiritual wellbeing, psychological distress, and overall quality of life. These findings were further echoed in the introduction of Milner et al.'s (2020) systematic review, which stated that spiritualities were 'fundamental to many people's lives, health and wellbeing and are crucial for the effective delivery of holistic and person-centred care'. Collating all these findings provides some support for the notion that spirituality can be used to improve people's mental health.

There was a small amount of literature focusing on social health. For example, it was demonstrated that offering a transport programme to help isolated elderly people to attend spiritual gatherings would be beneficial to their health (Hosseini, Chaurasia and Oremus, 2019), as it gives them an opportunity to engage with other people and practise their spiritual beliefs as a collective. Liefbroer et al. (2017) additionally highlighted the importance of mental health professionals being aware of, and prepared to, support the spiritual dimension of people using Public Health services. For Public Health practitioners, there was research to show that practitioners should not overlook the benefits of enabling spiritual practices among adults as a form of social interaction (Hosseini, Chaurasia and Oremus, 2019; Milner et al., 2020). These findings can play a vital part in Public Health research, illustrating the role of spirituality in facilitating an improvement in elements of people's health.

2.6.2.3 The literature focuses on specific facets of health

As discussed in the previous section, the literature mostly concentrated on specific facets of people's health. Braam and Koenig (2019), Smith-MacDonald et al. (2017), and Milner et al. (2020) were predominantly concerned with mental health, while Gonçalves et al. (2017) and Moreira et al. (2020) mainly investigated physical health in relation to spirituality. A critique of this approach is that because they focus solely on one aspect of health; thus, other areas of health are not considered. This approach might lead to the omission of a substantial amount of research on other dimensions of health for example spiritual or societal health. To further support this point, Carlson (2012, in Hulett and Armer, 2016) argues that not only is focusing on certain aspects of health a limited approach, but the recruitment of a study population also based on particular disease characteristics, rather than psychosocial-spiritual considerations, may result in unintended participant stress and impede the measurement of the intervention's therapeutic value, due to only providing a partial understanding of the phenomena. Failure to consider health holistically can mean that health practitioners and researchers may miss important findings, such as a combination of these factors on people's health simultaneously.

2.6.2.4 Summary

In answer to outcome two (How the literature treats or frames the relationship between spirituality and Public Health), this review concludes that there is some consensus amongst researchers that there is a positive association between spirituality and Public Health. The literature treats spirituality as a technique to help people cope with illness (Schreiber and Brockopp, 2012; Wang, Chow and Chan, 2017; Weaver et al., 2003), as spirituality provides a sense of support (Braam and Koenig, 2019) and protection (Weaver et al., 2003). It could be argued previous research has focused on specific elements of people's health rather than holistically addressing health. Yet the problem for researchers and health practitioners is the difficulty of agreeing on the definition of these different meanings, and subsequently, there is a lack of consensus around how the concept of health might be operationalised. Once this obstacle has been removed, it would become possible to determine what aspects of health should or could be measured. Given the cultural, spatial, and even temporal contingency of the concept, the possibility of arriving at any shared understanding is vital from a Public Health perspective in order to be able to apply it to health promotion, policy, and practice.

It is evident that the previous research also concentrated on people with poor health, such as coping with illness, and its relationship to spirituality. There was some extant literature on mental and physical health and spirituality. Public Health practitioners should not overlook these identified benefits of enabling spiritual practices for patients (Hosseini, Chaurasia and Oremus, 2019; Milner et al., 2020). Additionally, practitioners need to be mindful of the variations in the findings and the potentially negative associations, yet they have not been established in the systematic review. From a Public Health perspective, the current research studies need to operationalise health more clearly into different dimensions. This would enable a deeper understanding of this relationship and provide insight into the bidirectional relationship between spirituality and health.

2.6.3 Which methodologies appear to be most dominant in the area of research

A majority of the studies presented in these systematised reviews have employed quantitative methods. Out of the eighteen systematic reviews included in this analysis, twelve were quantitative methods (the designs included: empirical research, randomised control trials and non-randomised control trials, prospective quantitative methods) (Gijsberts et al., 2011; Gonçalves et al., 2017; Hai et al., 2019; Hosseini, Chaurasia and Oremus, 2019; Hulett and Armer, 2016; Lewis, 2007; Monod et al., 2011; Moreira et al., 2020; Schreiber and Brockopp, 2012; Thune-Boyle et al., 2006; Wang, Chow and Chan, 2017), two were qualitative methods (the designs included: any qualitative studies, for example, interviews and focus groups) (Liefbroer et al., 2017; Milner et al., 2020), two were mixed methods

(including qualitative and quantitative studies) (Gordon et al., 2018; Smith-MacDonald et al., 2017) and two systematic reviews included both quantitative and qualitative methods (but not mixed methods studies) (Selman et al., 2011; Weaver et al., 2003). Table 7 shows the types of methods examined in each of these systematic reviews.

Table 7: Types of methods examined in the systematic literature review

First author*	Types of methods examined in the systematic review	How many studies were included in the systematic reviews
Braam	Quantitative - Prospective, empirical and Randomised Control Trial (RCT),	152
Gijsberts	Quantitative – Empirical	36
Gonçalves	Quantitative – RCT	30
Gordon	Mixed - Methods including quantitative and qualitative studies and mixed methods	26
Hai	Quantitative – RCT	20
Hosseini	Quantitative - Comparison group	17
Hulett	Quantitative - RCT and non- RCT	22
Lewis	Quantitative - Any relevant quantitative study	25
Liefbroer	Qualitative - Any relevant qualitative study	22
Milner	Qualitative - Any relevant qualitative study	38
Monod	Quantitative - Any clinical studies spiritual assessment instrument	22
Moreira	Quantitative - Cross-sectional design	9
Schreiber	Quantitative - Any relevant quantitative study	18
Selman	Quantitative and Qualitative - Any relevant quantitative or qualitative study	191
Smith-MacDonald	Quantitative and Qualitative and Mixed methods - A mix of empirical studies.	43 (37 quantitative, 5 qualitative and 1 mixed methods)
Thune-Boyle	Quantitative - Any relevant quantitative study	17
Wang	Quantitative – RCT	8
Weaver	Quantitative and Qualitative - Any relevant quantitative or qualitative study	468 (364 quantitative and 34 qualitative, 54 general topic review and 14 papers on treatments)

*The full list of authors and references can be found in Appendix 3.

In total 1164 papers were included in the systematic reviews. There may have been more quantitative studies due to the way the search strategy was conducted, as systematic reviews tend to favour randomised control trials (Dixon-Woods et al., 2006). Weaver et al. (2003) suggest that the benefit of quantitative data is that the analysis naturally leads to a consideration of what research says about spirituality and health concerning salient clinical issues. Regarding spirituality and health, quantitative research can give consistent insights and measures (Weaver et al., 2003). Braam and Koenig (2019) recommended the importance of including both qualitative approaches and a mixed methods design,

to determine how different aspects of spirituality affect individuals in the study. A qualitative approach can provide insights into ways in which the concept of spirituality was operationalised (Weaver et al., 2003). A strength of qualitative data is that it can provide explanations of complex occurrences that are beneficial in evolving or creating conceptual bases or theories. Furthermore, for spirituality and health research, these different methods can provide a range of different understandings of the relationship between spirituality and health (Weaver et al., 2003). Qualitative data can help to operationalise the terms, while quantitative studies can make the data quantifiable (Weaver et al., 2003). The appropriateness of the methods used needs to be taken into consideration when exploring spirituality and health. This also depends on what the research is trying to do, for example, measure a relationship or understand people's attitudes towards that relationship.

Weaver et al. (2003) discovered that nearly half of the quantitative studies focused on measuring spiritual affiliation. This is in contrast to qualitative studies, which tended to centre on people's feelings about their experiences. Although they did not refer to any mixed methods studies, this would indicate that different methodological approaches might produce different results and affect the findings of the studies (for example, qualitative studies can provide more emotional responses, while quantitative studies can give numerical and quantifiable data). They found the quantitative and qualitative studies examined elements of spirituality in different ways, for example, quantitative questions on 'how many times they engaged with spiritual activities' and qualitative questions such as 'how spirituality was defined' (Weaver et al., 2003). This has been made even more complicated by the lack of clarity around how spirituality is interpreted. Different methodological approaches invariably produce different results because they examine the same phenomena in different ways, consequently providing different results (Braam and Koenig, 2019; Monod et al., 2011; Weaver et al., 2003). When conducting future Public Health investigations, then, the choice of methodology is a critical factor to consider.

Another factor affecting the methods is that the systematic reviews differed substantially in terms of study populations, intervention components, comparison groups, and outcome measures; for example serious illnesses, such as cancer (Hulett and Armer, 2016), depression (Braam and Koenig, 2019), or substance use issues (Hai et al., 2019) might lead to divergent results. Different populations might derive different benefits from their understandings of spirituality: end of life care research might show that terminally ill patients' belief in an afterlife helped them to cope, whereas patients with substance issues might find the social and community support elements of spirituality comforting, for instance. Spiritual beliefs are generally personal to the individual (Hai et al., 2019). Therefore, the perceived effects on health can also be individual.

2.6.3.1 Summary

In answer to outcome three (which methodologies appear to be most dominant in the area of research), quantitative studies were the most dominant in terms of methodology. Although quantitative approaches have their strengths, they could also miss other potential findings, as quantitative and qualitative studies examine spirituality differently (Weaver et al., 2003). The benefits of these separate approaches are that quantitative analyses can enable the data to be measurable, and qualitative analyses can ensure the data is ready to be operationalised and provide deeper insight. Therefore, more studies investigating spirituality and health using varied approaches might be of benefit to reveal new insights. There are methodological issues about how the terms 'spirituality' and 'health' are defined as well as the variables being measured, as various studies operationalised the terms differently. The population being studied can also be affected by the methods used. For example, it might not be possible to interview the whole population or ask someone who could not read or write to fill out a quantitative survey. Therefore, a broader examination of spirituality and health using a mixed method study could help to generate greater insight into this topic.

2.6.4 Current validated spiritual tools used in Public Health

This section provides an overview of some of the validated spiritual tools identified in the literature; it is divided into five sections: 2.6.4.1 an overview of the spiritual tools; 2.6.4.2 variations within the tools; 2.6.4.3 measures of spirituality; 2.6.4.4 measures of health; 2.6.4.5 critique of the current validated spiritual tools.

2.6.4.1 An overview of spiritual assessment tools

This systematised review identified four systematic reviews that specifically examined spiritual tools used within the research studies: 1) Gijsberts et al. (2011) conceptualise spirituality by identifying dimensions, based on instruments measuring spirituality in end-of-life populations; 2) Lewis (2008) explored the spiritual assessment tools used to measure African-Americans' relationships between spiritual tools and health; 3) Monod et al. (2011) systematically reviewed the instruments used for measuring spirituality in any clinical health research; 4) Selman et al. (2011) evaluated measures of spiritual tools in across-cultural applicability in palliative care populations. Table 8 summarises the number of spiritual tools identified in each paper.

Table 8: Spiritual Assessment Tools

Author*	Population	Number of Spiritual tools identified	Number of valid Spiritual tools identified**
Gijsberts et al. (2011)	Palliative care	24	9
Lewis (2008)	African Americans	10	5
Monod et al. (2011)	Clinical research	63	35
Selman et al. (2011)	Palliative care	85	38

* The full list of authors and references can be found in Appendix 3.
** The full list of valid spiritual tools is presented in Appendix 4.

The present systematised review sheds light upon many current validated spiritual tools used within the literature. Validated spiritual tools are instruments that have undergone some sort of examination process using a representative sample, demonstrating adequate reliability and validity of the tool to measure spirituality (Tsang, Royse and Terkawi, 2017). Non-validated spiritual tools are instruments of spiritual measures that have not been validated due to currently being theoretical and not tested or implemented within a population (Tsang, Royse and Terkawi, 2017). Out of these four systematic reviews, one hundred and eighty-two spiritual tools were found, and eighty-seven of them were considered as validated spiritual tools (presented in Appendix 4). There was some duplication of the spiritual tools identified within each of these papers. For example, the 'JAREL Spiritual Wellbeing Scale' appeared in each of these systematic reviews. Other validated spiritual tools identified in some of these systematic reviews included: the Spiritual Needs Inventory; the Spiritual Wellbeing Scale; the Spiritual Wellbeing Questionnaire; the Spiritual Perspective Scale; and the Spiritual Assessment Tool. Once all the duplications were removed, this left sixty-nine validated spiritual tools. These tools highlight the amount and diversity of the measurements used within the literature.

2.6.4.2 Variations within the tools

There are wide variations within these validated spiritual tools, as the aspects being measured differ. For example, some measure 'hope', 'pain' and 'quality of life' in relation to spirituality. Several of the tools explicitly included and measured faith-based aspects in the title, for example, 'The Multidimensional Measure of Religiousness/Spirituality' (which included aspects of prayer and church) and some solely focus on spirituality, such as 'The Spirituality Index of Wellbeing'. Many of these spiritual tools are used in specific health settings, or with a specific population of people, for example in a clinical setting (Monod et al., 2011) or end of life care (Gijsberts et al., 2011; Selman et al., 2011).

Several of the validated spiritual tools identified were 'needs assessment tools' (meaning assessing what the patients' needs or requirements were), with spiritual needs as an added dimension. Examples of these tools include the 'Cancer Worries Inventory', 'Hope Differential-Short', and 'Needs Assessment for Advanced Cancer Patients' (Selman et al., 2011). However, spirituality was not the primary focus of these tools and only one element of these measures. A critique of 'needs assessment tools' in themselves is that they can be seen as a reductionist way to assess health needs, as a needs assessment tool tends to be for those who are experiencing ill health, and it is only helpful if it offers concrete evidence to determine which solution is the best for achieving the desired results. Gijsberts et al. (2011) and Selman et al. (2011) also note that many of the validated spiritual tools were developed and used specifically in the context of nursing. This could be an issue when applying them to Public Health, as the tool might not be applicable to a broader population.

2.6.4.3 Measures of spirituality

Most of the quantitative papers measured spirituality using Likert scales (Monod et al., 2011). The questions tended to ask the participants how they felt about their spiritual wellbeing or faith on a scale. For example, in the JAREL Spiritual Wellbeing Scale, one of the questions is 'I believe I have spiritual wellbeing' and the participants then have to rate on a Likert scale between 1-5 if they 'strongly agree' or 'strongly disagree' (Monod et al., 2011).

The dimensions of spirituality that were incorporated in the tools included spiritual beliefs, participation degree of spirituality (low vs high), attendance at spiritual settings (more than weekly, weekly, monthly, or never), and organisational and non-organisational spiritual activities (Hosseini, Chaurasia and Oremus, 2019). Although the focus of this literature review has been on spirituality, it would be misleading not to acknowledge that some dimensions of spiritual measurements incorporated religious elements, such as prayer, church attendance, and at times religious affiliation (Hosseini, Chaurasia and Oremus, 2019). However, Hai et al. (2019) critiqued the measure of spiritual outcomes as one entity, as this included a merging of spiritual wellbeing, daily spiritual experience, spiritual practice, and spiritual coping. It is also important to note the purpose of the tool for the setting it was designed to be applied in. For example, this tool used in a cancer setting might measure different aspects of spirituality and health compared to another validated spiritual tool that was designed to measure spirituality in people who are diagnosed with depression or HIV.

As previously mentioned, one of the issues with the literature was that there was a large amount of disparity over how spirituality is measured within the validated spiritual tools (Hai et al., 2019;

Hosseini, Chaurasia and Oremus, 2019; Selman et al., 2011). To illustrate this variation, Selman et al. (2011) conducted a content analysis of the spiritual concepts in the measures which identified six themes: (1) beliefs, practices, and experiences; (2) relationships; (3) spiritual resources; (4) outlook on life or self; (5) outlook on death or dying; (6) indicators of spiritual wellbeing. Hosseini, Chaurasia, and Oremus (2019) discovered measures of spirituality in validated spiritual tools, which categorised responses differently. These included intrinsic beliefs, organisational and non-organisational activities, and frequency of spiritual practices (Hosseini, Chaurasia, and Oremus, 2019). However, Gijsberts et al. (2011) found that measures of spirituality included belief, practices, and other contextual factors, which were mostly related to a person's dimension of spiritual health. These findings further confirm the numerous inconsistent ways spirituality is measured within these tools and the area of research more generally.

2.6.4.4 Measures of health

In the same way as the measures of spirituality, calculations of health tended to be presented as Likert scales. A handful of the systematic reviews did not discuss how health is measured, whereas other studies measured health by asking the participants how much they engaged in health-harming behaviour. To illustrate this point, Hai et al. (2019) focus on substance use outcomes, particularly analysing use frequency and abstinence rate. Gijsberts et al. (2011) discuss the Functional Assessment of Chronic Illness Therapy- Spiritual Well Being Scale (FACIT-Sp-12) which is a validated tool, measuring the dimensions of health as being 'mental', 'emotional', and 'functional wellbeing'. The FACIT-Sp tools posit twelve questions concerning health. For example, it asks whether an individual illness 'has strengthened (…) faith or spiritual belief', and whether the individual experiences 'trouble feeling peace of mind,' which could be seen as dimensions of mental health. In comparison, the 'JAREL Spiritual Wellbeing Scale' focused on spiritual health in more depth. For example, it asks: 'Do you believe you have spiritual wellbeing?' or 'Do you feel a connection with others?' (Monod et al., 2011). These two examples highlight the huge variation of how health is measured and the lack of consensus around validated spiritual tools. Phrasing the question in a different way may produce differing results, especially when considered within different dimensions of spirituality and health. Consequently, there is a potential need to be more explicit about how research into this area is being conducted and measured; importantly, variation should be a crucial consideration when implementing spiritual tools.

2.6.4.5 Critique of the current validated spiritual tools

With the growth in research in spirituality and health in recent years, the number of outcome measurement tools has proliferated, for example: Hall, Meador, Koenig, (2008); Slater, Hall and Edwards, (2001); Hill and Pargament (2003) in both Lewis, (2008) and Selman et al. (2011). The benefits of these validated spiritual tools include providing a measurement that treats everyone the same and identifies patients that may require additional spiritual support (Selman et al., 2011). Measures of spirituality are essential for health research, particularly in relation to testing spiritual interventions and investigating the relationship between spiritual variables and other health outcomes (Selman et al., 2011).

Limitations of the existing validated spiritual measures are presented as having predominantly been developed in the USA, among Caucasian populations, and have been criticised for cultural bias, conceptual imprecision, and psychometric weaknesses (Lewis, 2008; Selman et al., 2011). Lewis (2008) discussed that many of the research studies utilising these spirituality measures included limited numbers of African Americans in the population sample. Another critique by Monod et al. (2011) stated that none of these spiritual tools appeared completely robust enough to stand alone and measure spirituality or spiritual interventions because they did not capture all the elements of spirituality or health (such as social and societal health).

Some of the measures found are relatively new and therefore, have not had the opportunity to undergo psychometric scrutiny (Lewis, 2008). All these systematic reviews that recognise the measures require further testing for reliability when used in more everyday settings (Gijsberts et al., 2011; Lewis, 2008; Monod et al., 2011; Selman et al., 2011). None of the validated spiritual tools identified to date are considered universal and applicable to a wider population (Monod et al., 2011). However, it needs to be acknowledged that the research on validated spiritual tools is still in its infancy, and studies on various cultures and beliefs are therefore limited (Lewis, 2008). As a result, there is currently little guidance to inform the choice of spiritual assessment tools concerning Public Health and measuring spirituality on a wider scale. One suggestion is that future studies could examine the robustness of spiritual assessment tools, particularly ones used within Public Health.

2.6.4.6 Summary

In answer to outcome four (what current validated spiritual tools are used in Public Health), many validated spiritual tools used within research were found. The benefits of these tools include providing objective measurements and identifying patients that may require additional spiritual support. These

tools are constantly being developed and modified. The findings show there are some issues due to a lack of consistency with the variables being measured. The tools were predominantly designed for those experiencing ill health. As such, they did not encapsulate all the elements of spirituality, had only been used among specific populations of people or within certain healthcare settings, and the tools for spiritual measures all require further testing for reliability. Within Public Health literature, there is currently little guidance to inform the choice of which spiritual tools to use and where. Additional research around validated spiritual tools and more guidance on the appropriateness and relevance of particular tools to be used in specific Public Health contexts would enhance their uses within this field of health.

2.7 Limitations

Despite the comprehensive and systematic search and screening methods employed, some studies that met the inclusion criteria may not have been identified (Clarke and Crane, 2018; Hai et al., 2019). There was overlap in the systematic reviews with religion, therefore there was difficulty focusing on spirituality as an independent variable. There is also the matter of researcher bias as the interpretations are my own and have not benefited from the reflective thoughts of other researchers (Grant and Booth, 2009). Some other limitations pertain to the language restriction in the literature search, as studies may exist published in languages other than English (Braam and Koenig, 2019). This systematised review found its results on previous reviews' findings; thus, it is difficult to assess how reliable some of these results can be. For example, many of the reviews did not state the country of origin of the papers analysed in their systematic reviews. This might affect reliability as it was unclear at times in which country/context the research was situated. However, the CASP quality assessment was undertaken, and the reviews were deemed to be of high quality. Despite these limitations, this review is the first to synthesise the available evidence illustrating an association between adults' spiritual practices and/or beliefs and Public Health outcomes, which can provide insight for future studies.

2.8 Summary and outcomes

This systematised review has identified a sizeable body of research studies that have examined different aspects of spirituality. The studies mostly conclude that by integrating these aspects into public health, individuals' beliefs and practices around spirituality can influence different aspects of people's health. The results of this review help to enhance the knowledge in this area by bringing a range of findings together. It should be acknowledged there are difficulties in separating the terms

spirituality and religion in the literature; as a result, religious views are a limited part of the examined reviews, but it does not necessarily mean religion should then be included in the findings.

Some respectable and robust studies have been carried out on specific aspects of spirituality in relation to health in answer to the PEO. It was found that there was a generally positive association between spiritual beliefs and health. For some individuals, spiritual beliefs supported recovery by providing a sense of hope and support, while also functioning as a strong protective factor (Braam and Koenig, 2019; Weaver et al., 2003). For others, spirituality was shown to help by improving mental health and, thus, supporting quicker recovery times after illness (Braam and Koenig, 2019; Smith-MacDonald et al., 2017; Milner et al., 2020).

The literature review revealed that many of the studies addressed specific areas of healthcare, such as end-of-life care and ICU, and also targeted specific populations, for example those with cancer or depression. Even though these systematic reviews were conducted to a high standard, the results only represent certain populations, therefore the findings cannot necessarily be applied on a wider scale. The benefit of looking at the wider population rather than specific groups is that it is possible to attain a more holistic picture (Shaghaghi, Bhopal, and Sheikh, 2011), thus providing greater insights into this area of research.

A considerable amount of the literature within the systematic reviews was carried out in the USA and among recruited participants from faith-based establishments. Arguably, this population holds different attitudes to the UK population in relation to their beliefs (Braam and Koenig, 2019; Furman et al., 2005; Holloway et al., 2011; Miller and Thoresen, 2003; Rogers, 2016). It does need to be acknowledged there was little research specifically on the negative or null effect of spirituality on people's health. This might be linked to the fact that research tends to publish more positive results than negative ones (Braam and Koenig, 2019). This systemised literature review highlighted the importance of Public Health practitioners recognising the role spirituality can have in supporting people's health (Hosseini, Chaurasia, and Oremus, 2019; Milner et al., 2020).

Though this systematised review sought to focus on the spiritual, there was some confusion over the many meanings of spirituality. This is complicated further by the fact that spirituality and religion were both seen as distinguishable and overlapping concepts, and many systematic reviews are not always able to differentiate between spiritual and religious variables when analysing and presenting the results. Several problems have been noted when attempting to define spirituality. For instance, none of the systematic reviews appears to mention SBNR or to mention people who are not associated with major religions, let alone how this could influence health. This was also the case for the analysis of the

spiritual tools used to examine spirituality, as there was a wide amount of variation of what was encompassed and measured in the spiritual tools and how the data was being used. There appears to be only a limited amount of qualitative and mixed methods research, though there were some areas that the literature may not have explicitly been examined. Consequently, a mixed methods approach can include the theoretical foundation/paradigm the research is coming from.

The findings suggest there is a potential relationship between spirituality and Public Health, and this relationship tends to be reported as a positive one. There were three main outcomes of this systematised review: first, it could be argued there is a need to conduct more research on the role of spirituality within Public Health, and particularly studies of the elements of spirituality that affect health. This can include exploring spirituality in a wide range of contexts and settings (such as the general population). Second, there is a need for a distinction between key terms used within the literature, for example, 'spirituality' and 'religion', 'health', and 'Public Health'. Third, researchers should use different methods (for example, quantitative and qualitative data) to explore spirituality in relation to health to provide a wide range of insights into this relationship.

2.9 Second literature review

The previous literature review provided important foundations for this study, however, the next logical step was to examine if there was any empirical literature on adults who identify as SBNR, in relation to Public Health. The rationale for conducting this second literature review was to ensure no critical literature was omitted through a cohesive review of relevant qualitative, quantitative, and mixed methods studies, particularly focusing on those who identify as SBNR. This specific population forms the focus of this literature review for the following reasons: the last literature review identified overlaps between spirituality and religion; importantly, one way to deal with this issue is to focus specifically on spiritual elements through an analysis of specific populations that identity as SBNR, a focus which was highlighted as a gap in the first literature review that may have been missed due to the particular focus on systematic reviews.

For this literature review, SBNR is conceptualised as 'self-identified, a life stance of spirituality that takes issue with organised religion as the sole or most valuable means of furthering spiritual growth' (Mercadante, 2014). This definition was chosen because it is generally how SBNR is recognised within the literature (Day, 2013; Fuller, 2001; Mercadante, 2014; Mercadante, 2020; Parsons, 2018), and appeared to be the best definition to use to identify the appropriate literature (critiques of this definition are discussed in section 2.17.5). This phrase was used as an umbrella term for a wide range

of non-believers in a specific religion, for example Nones, Atheists, and Atheism (Mercadante, 2014). This is discussed in more detail in section 2.14.1.1.

A systematised review was chosen because, as previously stated, the field of Public Health tends to favour systematic reviews, as they are considered the 'gold standard'; they attempt to identify, appraise, and synthesise all the empirical evidence that meets the specific inclusion criteria to answer a highly focused research question (Dixon-Woods et al., 2005; Orton et al., 2011; Paudel, 2012; Pope, Mays and Popay, 2007; Smith and Noble, 2016). This seemed a good method to draw on the appropriate literature and incorporate the most relevant studies that were rigorous, of a high standard, and met the relevant criteria (Grant and Booth, 2009). As discussed in the previous section, a limitation of this approach is that it can be considered less rigorous, as only one researcher is conducting the study (Grant and Booth, 2009). Another criticism of this approach is that the quality, assessment, and synthesis of individual studies may be less identifiable (Grant and Booth, 2009). However, it was considered the best approach for this thesis, due to its ability to evaluate and summarise the findings of relevant research (Boaz, Ashby, and Young, 2002; Pericic and Tanveer, 2019; Petticrew and Roberts, 2008). A systematised review can help to provide a clear and comprehensive overview of this topic; it can be used to improve future work in this area, as well as identify the gaps in the literature (Pericic and Tanveer, 2019; Petticrew and Roberts, 2008). Using the same approach as the previous review, a systematised review of the related literature was carried out using the Khan et al. (2003) guidelines for consistency.

2.10 Framing the question for a review

A PEO question was developed to examine literature reviews to explore the relationship between adults who identify as SBNR and health. The PEO question and aim for this section of the literature review was:

'Is there an association between adults who identify as SBNR and Public Health outcomes?'

The PEO question can be separated in the following ways:

- **Population:** Adults who identify as SBNR, who are defined as aged 18+. This includes both healthy and unhealthy populations, for example, people with or without an illness.
- **Exposure:** To SBNR spiritual beliefs and practices.
- **Outcomes:** This includes outcomes related to Public Health policy, practice or specific health outcomes.

With this PEO question, the outcomes of the literature review explored the following four questions/outcomes:

1. How is the term SBNR currently being operationalised in Public Health literature?

2. How does the literature treat or frame the relationship between those who identify as SBNR and health?

3. Which methodologies appear to be most dominant in this area of research?

4. What measures are being used to examine those who identify as SBNR in the Public Health literature?

2.11 Identifying relevant research

The literature search strategy was divided into three stages: the first stage consisted of a search for the appropriate literature; the second stage examined the initial articles identified; finally, after the literature search was conducted, there was an evaluation of the quality of the sources found.

Timeframe

The search was limited to literature published between 1960 and 2020. This timeframe was chosen because the term 'SBNR' was first recognised in literature in the 1960s, as increasing numbers of people had turned to spirituality, rather than religion, as a source of solace and to find sanctuary from the busy consumer world (Hay and Hunt, 2000; Tischler, 1999; Roof, 2001). Research shows 'the designation SBNR became part of the popular lexicon as a distinctive marker of spiritual identity and practice' (Drescher, 2014, p.3) in the 1980s. By the late 1990s and early 2000s, the phrase 'Spiritual but Not Religious' appeared in mainstream literature as the search for meaning and fulfilment uncoupled from particular institutional or dogmatic commitments (Drescher, 2014). The literature end date was December 2020, when the final literature review was conducted. This chosen time scale appeared to be large enough to capture all the significant papers, as well as going back far enough to ensure no key sources were missed.

Inclusion and Exclusion Criteria

In line with the PEO, inclusion and exclusion criteria were developed to help gather the most appropriate literature. The inclusion and exclusion criteria were developed during the initial phase of the process of this literature review. To make sure that the reviewed articles encapsulated the essence of the research question, papers were included if they met the following criteria:

- Addressed the PEO question (**'**Is there an association between adults who identify as SBNR and Public Health outcomes?**'**) and the four outcomes (on page 87) of the current research about the relationship between those who identify as SBNR and health, within the context of Public Health.
- Were published in peer-reviewed journals with 'Spiritual but Not Religious' (SBNR) or other similar phrases (highlighted in the search terms sections below), appearing as an important factor in the title, abstract or key terms.
- Were empirical studies: this included qualitative, quantitative, or mixed methods studies.
- Were sourced from international/global sources/publications.
- English language publications.
- Adults (defined as 18+) were the participant population.
- Discussed any health conditions.

The exclusion criteria were developed to ensure that only unrelated articles were eliminated; articles were excluded if they failed to meet the following criteria:

- Were not empirical studies.
- Were studies on children, defined as being under 18, due to the fact that the focus was on adults.
- Articles that did not mention 'SBNR' (or other similar phrases highlighted in the search terms section) in the title, abstract, or key terms.

The inclusion and exclusion criteria were necessary to help narrow down relevant papers and address the PEO and the study's outcomes. A critique of using this approach is that it might miss relevant literature; however, it was deemed the best approach to capture the relevant articles.

Online searches

The literature was searched by using four academic online search engines: CINHAL, Ovid, PubMed, and Science Direct. These were accessed through CCCU Library Collection. These online databases were considered to cover the appropriate journals that tend to be the standard used within Public Health.

Search terms

To ensure no relevant literature was missed, the same search terms were used as before. However, the term 'systematic reviews' was not included in the search terms, as this review wanted to include all types of literature. The phrase 'spirituality' was also removed to help enable the literature review to focus on those who identify as SBNR and health. These search terms (identified in Table 9) were specifically searched for in the title, abstract, and keywords in all the online search engines. Within

the search engines, where applicable, a Boolean search term was used to help widen the search to make sure no relevant literature was missed (Fisher, 2020); shown in Table 9. Each database was further refined to meet the inclusion and exclusion criteria.

2.11.1 Stage one

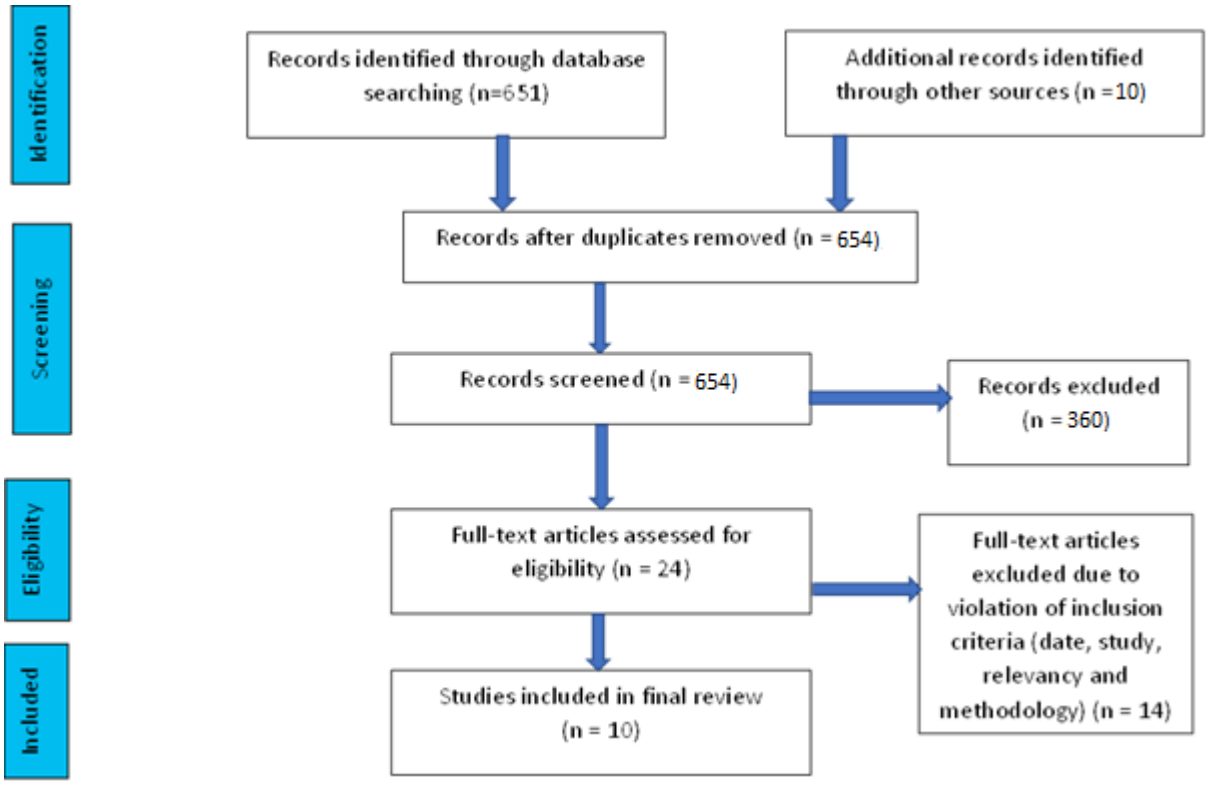
Within the four online search engines identified, using the key terms and refinement year, the search for the relevant literature commenced. Table 9 illustrates the number of sources found in each search engine.

Table 9: Searching for relevant literature

Search engine	Keywords/search string	Date the search was conducted	Paper published Refinement year	Number of sources found
CINHAL	("Public Health" OR health OR wellbeing) And ("Spiritual but Not Religious" OR SBNR OR "Spiritual but Not Affiliated" OR SBNA OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones)	6/5/2021	1960-2020	131
Ovid	("Public Health" OR health OR wellbeing) And ("Spiritual but Not Religious" OR SBNR OR "Spiritual but Not Affiliated" OR SBNA OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones)	6/5/2021	1960-2020	139
PubMed	("Public Health" OR health OR wellbeing) And ("Spiritual but Not Religious" OR SBNR OR "Spiritual but Not Affiliated" OR SBNA OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones)	6/5/2021	1960-2020	58
Science Direct	("Public Health" OR health OR wellbeing) And ("Spiritual but Not Religious" OR SBNR OR "Spiritual but Not Affiliated" OR SBNA OR secular OR atheists OR agnostics OR humanists OR non-religious OR Nones)	6/5/2021f	1960-2020	353

Initially, 681 articles were identified from a range of academic peer-reviewed journals, published in English, from around the world. There were 30 papers that were found in more than one of the search engines. This brought the initially identified papers down to 651 papers. Supervisors' and colleagues' recommendations on specific articles, topics, and authors were also included (n=10). These additional sources were included in Table 10 under 'additional records identified'.

Table 10: Flow diagram of the various phases of the systematic review inspired by PRISMA



2.11.2 Stage two

Once the literature had been obtained through the four search engines and compared to the additional sources identified all the duplicates were removed (n=7). The records were then screened (n=654); this included the titles, abstract and key terms. three hundred and sixty papers were excluded as the title and abstracts of these papers did not meet the inclusion criteria. This left twenty-four articles left for a full examination. The twenty-four articles that met the inclusion criteria were read carefully, analysed, and any relevant references that met the inclusion criteria and that were not already identified were followed up and included in the analysis (Aveyard, 2014; Booth et al., 2016; Fink, 1998). Once these twenty-four papers were fully read and examined, fourteen papers were considered not to meet the inclusion criteria (presented in Appendix 5), as some of the papers identified were excluded due to not being empirical studies (n=4) or peer-reviewed articles (n=4), not relevant to this research topic as they did not examine an SBNR population (n=2) or health (n=2). Additionally, one of the studies included children (n=1), and one was not translated into English and accessible (n=1). This left ten papers (three qualitative and seven quantitative studies) to be critically appraised.

2.11.3 Assessing the quality of studies

The remaining literature was then evaluated using the appropriate critical appraisal tools checklist. The three qualitative studies were assessed using the CASP Qualitative Critical Appraisal Checklist (2020), which is considered the standard quality assessment tool for qualitative research (Carroll and Booth, 2015; Dalton et al., 2017; Hannes and Macaitis, 2012; Long, French and Brooks, 2020). This approach has been critiqued for relying on the researcher's subjective interpretations (Noyes et al., 2018). There is little consensus among the academic community on what constitutes 'quality' in research (Long, French, and Brooks, 2020). Regardless of these critiques, the role of CASP was to provide an overview of the good, indifferent, or poor studies (CASP, 2020). This approach systematically assesses the trustworthiness, relevance, and results of published reviews (CASP, 2020). Table 11 demonstrates the CASP scores of the three relevant studies identified in this research. The scoring range was out of ten. These scores would be used to determine the quality of the paper. Any paper that scored above eight was considered high quality and thus was then included in this study.

The seven quantitative studies were assessed by using Cathala and Moorley's (2018) Quantitative Critical Appraisal Checklist. This approach provides a 'step by step' guide on how to appraise a quantitative paper critically; it was developed by researchers in the UK and was published in a peer-reviewed journal. However, there are limitations to this quantitative critical appraisal tool as it is fairly new, does not appear to be established in practice, and is not as well-known as the CASP tools. Despite this, it was decided this was the most appropriate approach to assess the quality of qualitative studies, because it helped to determine the quality of the studies rigorously and was developed in the context of health (Cathala and Moorley, 2018). Table 12 demonstrates the scores of the quantitative papers. The scoring range was out of twenty. Any paper that scored above fourteen was considered of high quality.

Table 11: Qualitative Critical Appraisal Checklist

Lead author*/ CASP questions	1.Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. Is the research valuable?	score
Mercadante	Y	Y	Y	Y	Y	C	Y	C	Y	Y	8
Van der Tempel and Moodley	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9
Watts	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10

* The full list of authors and references is in Appendix 6.

Key	**Score**
Y= Yes	1
N= No	0
C= Can't tell	0

The qualitative studies were assessed by taking each paper individually and checking it against each one of the CASP criteria (identified at the top of Table 11). In the same way as the CASP systematic review, the scoring systems work by having a 'yes', 'no' and 'can't tell' option and scoring each paper against the criteria. Based on the CASP assessment, out of the three qualitative studies identified, the Watts (2019) paper fully met all the ten criteria. There were several areas in which all these studies scored highly, for example, 'providing a clear statement', 'aim of the research question', and 'the overall results of the reviews were presented clearly'. The other two papers still scored highly, yet there was a lack of clarification between the 'researcher and participants being adequately considered', and whether 'the data analysis was sufficiently rigorous' (equally, this could be omitted due to a journal requirement for example, a strict word count). None of these studies was excluded from the literature review because they all scored eight or above, and consequently, can be considered reliable studies.

Each paper was checked against each of the criteria identified in the checklist for the quantitative studies. Similar to the CASP scoring systems, these papers were also assessed by having a 'yes', 'no' and 'can't tell' option and scoring each study against the criteria. There were twenty questions (identified at the top of the quantitative appraisal checklist in Table 12). The studies needed to score above fourteen to be considered robust and high-quality (Cathala and Moorley, 2018).

Table 12: Quantitative Appraisal Checklist

Lead Author*/ Quantitative Appraisal questions	Title: Is it clear, what is the length, is it accurate?	Keywords: Are the keywords reflective of the paper?	Author: What are the author's credentials, do they instil credibility and trustworthiness?	Abstract: Is the abstract present, and does it conform to an acceptable convention?	Hypothesis: Is the hypothesis or null hypothesis stated?	Research question: Is the question clear or are there clear aims and objectives?	Literature review: Is the literature used peer-reviewed, current and does it support the topic of the paper?	Sample: Is the sample appropriate, and does the size allow generalisation?	Ethics: Does the study have ethical approval and if not, is this adequately justified?	Design: Is the research design clearly stated?	Data collection: Is the data collection process clear including recruitment and consent?	Reliability and validity: Is the reliability and validity of the data collection adequately described?	Have any tools been piloted or pretested?	Data analysis: Did the researcher follow the steps of data analysis and is how the data was managed clear?	Results: Are the results accurate and presented in the correct format?	Discussion: Is there a logical flow and is the data placed in the context of the study and literature reviewed?	Has the rejection or acceptance of the hypothesis been discussed and developped?	Does the study consider the strengths and limitations of its findings?	Is the clinical significance or application to practice identified?	Are there future recommendations for practice?	Score
Baker	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Partly	Y	17.5
Hayward	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N	Y	N	N	14
Kelly	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N	Y	Partly	Y	14.5
McClure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Partly	Y	18.5
Saunders	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	C	N	Y	Y	Y	N	Y	Y	Y	16
Speed	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	18
Willard	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	18

* The full list of authors and references is in Appendix 6.

Key	Score
Y= Yes	1
N= No	0
C= Can't tell	0

The quantitative appraisal checklist shows that none of the seven studies met all of the criteria. However, they all met over half the criteria. There were several areas where all of these studies scored highly, for example, the title, keywords, and abstracts were all clear and appropriate. Furthermore, the authors were all well known in their fields and the research designs were clearly stated. An area where the quantitative studies did not score so highly was that none of them appears to have been piloted, or in any case there was no mention of this (equally, this could be omitted due to a journal requirement for example, a strict word count). Not all the studies identified a hypothesis and, at times, the application to clinical or Public Health practice was not specifically established. All quantitative studies were included in the literature review because they all met over fourteen the criteria, thus considered high quality (Cathala and Moorley, 2018).

2.12 Data extraction and analysis

All ten studies were included in the analysis. This second literature review restricts itself to summarising the findings narratively. Two tables (presented below) were designed to address the PEO and four outcomes (on page 88), as well as classify and identify major topics of relevance. In the same way as the first literature review, a review grid drawing upon the meta-summary approach illustrated by Aveyard (2014) was developed to gather the details of all selected articles. The grid development aimed to project the compiled data in an alphabetical and logical order to facilitate comprehension and systemise the articles (Aveyard, 2014).

2.13 Summarising the evidence

The data derived from the reviewed studies were placed into two tables. One focused on numerical data, the other focused on more detailed qualitative findings. Table 13 includes the name of the first author, the type and number of participants in total in each study, where in the world the study was conducted, the types of methods examined in the review, and the type of health that was discussed. Table 14 presents the aim, the key findings, the recommendations, and a few critiques of each study.

Table 13: Summary of the SBNR studies on descriptive characteristics

First author*	Year	Population (n= number of participants)	Data type	Where the study was conducted	What sort of health is being discussed
Baker	2018	Atheists and secularists (n= 1714)	Quantitative (national study)	USA	Mental and social health
Hayward	2016	Non-affiliated (including atheists, agnostics, and those with no religious preferences) (n= 3,010)	Quantitative (national survey)	USA	Wellbeing
Kelly	2020	SBNR population with substance issues (n= 2,002)	Quantitative (online questionnaire)	USA	Addiction issues
Mercadante	2020	General American population who identified as SBNR (n= 100)	Qualitative (90 interviews and 2 focus groups)	USA	Mental and social health
McClure	2020	SBNR population with substance issues (n= 1,711)	Quantitative (national survey)	USA	Addiction issues
Saunders	2020	SBNR USA general population (n= 35,071)	Quantitative (online questionnaire)	USA	Mental health
Speed	2016	Atheists from America general social survey (n= 3,210)	Quantitative (national survey)	USA	Positive health outcomes
Van der Tempel	2020	Atheists in the USA (n= 8)	Qualitative (Interview data)	USA	Psychological distress, and wellbeing
Watts	2019	SBNR Millennials with substance issues (n= 8)	Qualitative (interview data)	Canada	Addiction Issues
Willard	2017	SBNR Americans with mental health issues (n=1,013)	Quantitative (online questionnaire)	USA	Mental health

* The full list of authors and references is in Appendix 6.

Table 14: Summary of SBNR studies' key findings

First author*	Aim of the study	Key findings	Future recommendations	Critique
Baker	To assess potential differences in physical and mental health for different types of secular Americans.	Better physical health outcomes for atheists compared to other secular individuals and members of some religious traditions. Atheists reported significantly lower levels of psychiatric symptoms (anxiety, paranoia, obsession, and compulsion) compared to both other seculars and members of most faith-based traditions. Physical and mental health were significantly worse for non-affiliated theists compared to other seculars and religious affiliates on most outcomes. These findings highlight the necessity of distinguishing among different types of secular individuals in future research on health.	Examine the extent to which atheists and agnostics differ in their ability to draw such psychosocial resources from secular identity.	Strengths Shown consistent differences between atheists, agnostics, and non-affiliated theists concerning physical and mental health. Limitations The data is cross-sectional, so we are unable to disentangle issues of reverse causation between health and religious or secular identity. A relatively small category of secular individuals.
Hayward	To explore differences in mental and physical health outcomes, as well as in some of their key precursors, among the religiously affiliated and three categories of non-affiliated individuals atheists, agnostics, and those with no religious preferences.	Religious non-affiliates did not differ overall from affiliates in terms of physical health. Outcomes (although atheists and agnostics did have better health on some individual measures including body mass index, number of chronic conditions, and physical limitations), but had worse positive psychological functioning characteristics, social support relationships, and health behaviours. On dimensions related to psychological wellbeing, atheists and agnostics tended to have worse outcomes than either those with a religious affiliation or those with no religious preference. As the rise of non-religious affiliation continues, these results have implications for future healthcare needs.	More research on non-affiliated individuals and how this affects health outcomes.	Strengths Found different beliefs impact health differently. Limitations Uses data from a larger representative survey study of religion and health in the adult USA population.
Kelly	To investigate the role of spirituality and religiousness in aiding recovery from alcohol and other drug problems	Spirituality, but not religion, appears to play a role in aiding recovery, particularly among those with prior treatment or 12-step histories, but women and men, and racial-ethnic groups, in particular, differ strikingly in their religious and spiritual identity and the role these have played in aiding recovery. These differences raise the question of the potential clinical utility of spirituality in personalised treatment.	To capture dynamic shifts longitudinally in the same individuals over time.	Strengths Examines the role of spirituality in aiding recovery from alcohol and other drug problems. Limitations Reported findings here rely on self-report, are largely descriptive, limited in detail, and reflect perceptions about the role that spirituality and religiousness have played in aiding recovery. Cannot surmise from these cross-sectional data the actual salutary role these spiritual/religious factors may have had on recovery, only their perceived value. The definition of spirituality and religion was not provided and was left to participants to define participants may have been confused as to their distinctness.

Mercadante	To examine the spiritual struggles of Nones and SBNRs	Nones' key struggles are in the areas of Self and Self-in-Relation. This is a vastly under-researched topic that will only grow in importance, given the rapid and continuing rise of the None population. Struggles related to identity and society.	More research on the None and SBNR population.	Strengths Examines spiritual struggles of SBNRs and Nones. Limitations Does not explicitly state the questions asked to the interview participants.
McClure	To see whether individuals who have attended substance abuse groups such as Alcoholics Anonymous are more likely to identify as SBNR.	Those who have attended substance abuse groups are more likely to identify as SBNR. Frequency of attendance in these groups is positively and significantly associated with being SBNR when compared to being both religious and spiritual.	Further research on the SBNR population with addiction issues.	Strengths Shows how SBNR population benefit from Alcoholic Anonymous groups. Limitations The primary independent variables used in this study explicitly mention Alcoholics Anonymous, they also include other less widespread substance abuse programs, such as Rational Recovery, which deploy techniques and strategies different from those used in A.A. or other 12-Step programs. The personal stigma associated with substance abuse, our findings may underestimate the prevalence of group attendance and thus reflect more conservative estimates.
Saunders	To help clinicians understand contemporary trends in patient spiritual orientation.	Given changing demographics of religiosity and spirituality, this article aims to help clinicians understand contemporary trends in patient religious and spiritual orientation. It first identifies and describes the evolving varieties of religion-spiritual orientation and affiliation, as identified in survey studies. Particular attention is given to the examination of those who identify as SBNR and None, which is important to mental health practice because many patients now identify as SBNR or None.	Further research on mental health outcomes among SBNRs and Nones, clinicians should conduct their idiographic analysis of what these designations mean for individual patients.	Strengths Assist clinicians in an understanding of contemporary trends in patient religious and spiritual orientation. Limitations Specific data on the mental health of the Nones are virtually non-existent.
Speed	To explore the relationship between atheism and health within the religion/spirituality–health literature.	Results indicated that atheists experienced religiosity more negatively than non-atheists. Non-belief in God was not related to better or worse perceived global health, suggesting that belief in God is not inherently linked to better-reported health. Found extant literature has consistently failed to explore whether the salutary relationship between R/S constructs and health is moderated by what a person values.	Further research on atheism and health.	Strengths Provides insight into the relationship between atheism and health. Limitations Only focused on one health outcome: Self-Rated Health. Relies on national survey data and did not conduct their research.
Van der Tempel	To explore the meaning and mental health implications of spontaneous mystical experience (SME) reported by a sample of atheists.	Challenges in reconciling the SME with secular views and values were common and linked to varying degrees and durations of psychological distress, especially in relation to negative reactions from the social environment. No participant embraced organised religion, but most adopted more agnostic or spiritual worldviews, and ultimately associated their SMEs with enhanced wellbeing in various domains. Participants who reported persisting doubt and preoccupation about their SMEs experienced deteriorating mental health.	Longitudinal research is needed to track changes in SME interpretations over time and assess the effects of having multiple SMEs and other anomalous experiences.	Strengths Explores the meaning and mental health implications of SME reported by a sample of atheists. Limitations The sample size was relatively small and theoretical saturation may not have been optimally achieved.

			Multidisciplinary approach that incorporates anthropological and philosophical concepts and methodologies may be best suited to address the broader societal, epistemological, and ontological concerns raised by atheists with SMEs living in multicultural societies with secular Public Health systems.	Sampling may have been influenced by participant self-selection bias resulting from references to "mystical experiences" in the study materials, despite providing secular definitions of SMEs. All data was self-reported, including mental health status, the possibility that some SMEs were associated with unknown psychopathology cannot be ruled out. Third, the themes resulting from the analysis cannot be presumed to represent an exhaustive account of the participants' experiences, nor can they be reliably generalised to the sample population or individuals outside of it. Meaningful associations between themes were suggested based on connections with previous literature, any causal relationships cannot be verified beyond the attributions made by participants themselves.
Watts	To understand better what it means to these individuals to be 'spiritual as opposed to being 'religious'.	The young people's experiences of addiction provide insight into the trappings of free-market capitalist modernity and its inability to provide an overarching source of meaning to their lives. Addiction becomes how these individuals experience the malaise of modernity, which in turn leads them to seek an alternative understanding of the good life. A process they equate with spirituality. An interest in spirituality ought to be understood as a personalised attempt to re-enchant what is experienced as a disenchanted world.	Greater research into the growing divide between spirituality and religion.	Strengths Shed insights into what it means to these individuals to be 'spiritual as opposed to being 'religious'. Limitations This paper does not acknowledge the limitations of their research.
Willard	To assess the profile, in terms of cognitive biases and beliefs, for the SBNR in comparison to religious and non-religious participants.	The SBNR differ from non-religious and religious participants in several ways. SBNR participants are more likely to hold paranormal beliefs and to have an experiential relationship to the supernatural (for example, have mystical experiences and feelings of universal connectedness), but are similar to religious participants in their profile of cognitive biases. SBNR participants score higher on measures of schizotypal than religious or nonreligious. Reported conversions from one group (religious, SBNR, or nonreligious) to another since childhood corresponds with predictable differences in cognitive biases, with dualism predicting conversion to religion and schizotypal predicting conversion to SBNR.	Further examination of the relationship between schizotypal and SBNR and non-religious participants.	Strengths Explores SBNR populations beliefs concerning mental health. Provides new insight into the SBNR population. Limitations Focused on people with mental health issues. Therefore, it would be difficult to apply these findings to other populations.

*The full list of authors and references is in Appendix 6.

Within the papers analysed, there were a total of 52514 participants in all the studies combined. All of the reviews were conducted in the USA, apart from Watts' (2019) paper which was conducted in Canada. All the studies were published after 2011, indicating this is currently a growing area of research. The highest number of papers published in a year was five, in 2020. The focus of these ten papers can be broadly divided into four main categories: mental and social health issues (n=4.5), addiction issues (n=3), wellbeing (n=1.5), and positive health outcomes (n=1).

2.14 Interpreting the findings

To address the four outcomes at the beginning of the second literature review, the discussion was organised into four sections: 2.14.1 how is SBNR currently being operationalised in Public Health literature; 2.14.2 how does the literature treat or frame the relationship between SBNR and Public Health; 2.14.3 which methodologies appear to be most dominant in this area of research; and finally, 2.14.4 how SBNR is measured in Public Health.

2.14.1 How is SBNR currently being operationalised in Public Health literature

A majority of the papers noted a rise in the numbers of those identifying as SBNR (Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Mercadante, 2020; Saunders et al., 2020; Watts, 2019; Willard and Norenzayan, 2017). The rise of SBNR is a global phenomenon that appears to be developing in both Eastern and Western parts of the world (Mercadante, 2020; Saunders et al., 2020). To address outcome one, this section is divided into three sections: 2.14.1.1 the characterisation of the SBNR population; 2.14.1.2 the definition of SBNR; and 2.14.1.3 how SBNR defines spirituality.

2.14.1.1 The characterisation of the SBNR population

There is variation over how the SBNR population is characterised within the literature. Six of the studies identified in this literature review specifically focused on the SBNR population (Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Mercadante, 2020; Saunders et al., 2020, Watts, 2019; Willard and Norenzayan, 2017); two studies explicitly explored atheist populations (atheists are defined as those who disbelieve or lack belief in the existence of God/s) (Speed and Fowler, 2016; Van der Tempel and Moodley, 2020); one study specifically explored atheist and secularist populations (secularists are defined as those who advocate separation of the state from religious institutions) (Baker, Stroope and Walker, 2018); one study grouped non-affiliated individuals (non-affiliated people are defined as those who specifically do not associate themselves with a particular group) in a single study (this included atheists, agnostics, nones and those with no religious preferences) (Hayward et al., 2016). However, within the six studies that specifically examined the SBNR population, this also included some of these

other categories previously mentioned, such as atheists and secularists. All the data identified focused on groups that could be seen to come under the SBNR categorisation as secular, non-affiliated, but did not specifically state SBNR.

To further illustrate this, there appears to be variation within the SBNR population. This variation comprises those who self-identified as secularists, atheists, agnostics, non-affiliated, humanists (humanists are defined as people who reject the idea or belief in a supernatural being such as God, but seek to live ethical lives on the basis of reason and humanity), nones (nones are defined as those who are unaffiliated with any organised religion); some used hybrid designations (such as Christian-Buddhist-Pagan), and some sporadically attended organised religion or alternative spiritual groups (Mercadante, 2020). Others define themselves as holding a spiritual belief but do not believe in a singular God (Baker, Stroope and Walker, 2018; Mercadante, 2020). McClure and Wilkinson (2020) have taken a slightly different stance and identify the SBNR population as a form of 'post-Christian spirituality'. By their admission, SBNRs eschew organised religion and prefer instead self-directed approaches to spirituality (McClure and Wilkinson, 2020). McClure and Wilkinson (2020) advocate there is research to show people living in the USA who identify as both SBNR and religious, and even though there is a distinction between spirituality and religion, many people identify as being both depending on the context. This indicates the difficulty of categorising the specifics of people's beliefs.

Mercadante (2020) argues that the SBNR expression is more than a mere semantic shift, as SBNRs have a distinct theological outlook that often runs contrary to traditional religious beliefs and practices. This was also echoed by McClure (2017), who argues that SBNRs are more likely to view God as a Higher Power or Cosmic Force when compared to those who are both religious and spiritual, and SBNRs are more likely to reject the perceived moral authority of God or the Bible in favour of an individualistic code of ethics. This adds to the complexity of studying the SBNR as there is a lot of variation within the population. In addition, this categorisation of the USA SBNR population might differ from other countries.

There did not appear to be significant amounts of research on the demographics of those who identify as SBNR. There was some research to suggest non-theists (as opposed to atheists) tend to be younger, have higher levels of social class, and exhibit low levels of supernaturalism in general, while non-affiliated theists have lower levels of socioeconomic status and tend toward personalised amalgams of supernatural beliefs (Baker, Stroope and Walker, 2018).

2.14.1.2 Definition of SBNR

The majority of the literature identified adopted Mercadante's (2014; 2020) definition of SBNR (Hayward et al., 2016; Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Mercadante 2020; Willard and Norenzayan, 2017). Mercadante (2014; 2020) defines SBNR as 'self-identified, a life stance of spirituality that takes issue with organised religion as the sole or most valuable means of furthering spiritual growth'. Mercadante (2020) claims not only that for those who identify as SBNR, religious belief is non-essential, but that it is potentially harmful, or at least a hindrance to spirituality. This definition does not appear to be contested within the literature identified.

2.14.1.3 SBNR defining spirituality

There was variation over how spirituality was defined within the literature. In the same way as the previous literature review, some studies did not specifically define spirituality, for example Baker, Stroope and Walker (2018), and Hayward et al. (2016). Watts (2019, p.30) understood spirituality 'as a personalized attempt to re-enchant what is experienced as a disenchanted world'. However, Kelly and Eddie (2020, p.117) imply that, in the context of addiction, spirituality is understood as 'a broader recognition of powers greater than oneself and a broad array of associated beliefs and practices that may or may not fit within the realm of different religions and are more likely to be self-defined and self-governed'. Saunders et al. (2020) used this definition of spirituality; 'a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices' (Saunders et al., 2020). Table 15 illustrates all the definitions of spirituality included in these studies. These differing definitions highlight the disparity over how spirituality is defined, thus further supporting the findings of the previous literature review.

Table 15: SBNR definition of spirituality

First author*	Definition of spirituality
Baker	Not specifically defined.
Hayward	Not specifically defined.
Kelly	Broader recognition of powers greater than oneself and a broad array of associated beliefs and practices that may or may not fit within the realm of different religions and are more likely to be self-defined and self-governed.
Mercadante	Personal, heartfelt, and authentic.
McClure	Not specifically defined.
Saunders	A dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred.
Speed	Not specifically defined.
Van der Tempel	Self-transcendent sense of unity; intense positive affect; and a sense of revelation of meaning and purpose.
Watts	A personalised attempt to re-enchant what is experienced as a disenchanted world.
Willard	The individual experience of the supernatural.

* The full list of authors and references is in Appendix 6.

Those studies which defined spirituality, although quite diverse in their definitions of the term (which could be due to the context within which they were created), did appear to have a few similar themes that could be grouped together. These included 'personalisation' (Kelly and Eddie, 2020; Mercadante, 2020; Saunders et al., 2020; Van der Tempel and Moodley, 2020; Watts, 2019; Willard and Norenzayan, 2017), and 'meaning and purpose' (Saunders et al., 2020; Van der Tempel and Moodley, 2020).

There was a clearer distinction between spirituality and religion in the SBNR literature. Willard and Norenzayan (2017, p.183) suggested that 'spiritual' refers to the individual experience of the supernatural, while 'religion' represents an institutional affiliation that is less about unique individual experiences and more about shared doctrines. This separation was also noted by Mercadante (2020, p.1), who defined spirituality as 'personal, heartfelt, and authentic,' while religion was defined as 'external, structured, and non-essential', although this could be debated and critiqued by arguing religion holds deeper meanings than this. The SBNR population, with their presumed focus on the privacy of individual experience, offer an opportunity to investigate forms of supernatural belief and experience that often fall under the label of spirituality, a construct that is overlooked in the focus on organised religions (Willard and Norenzayan, 2017). In comparison to the previous literature review, spirituality was shown to be a distinct entity.

2.14.1.4 SBNR practices

Mercadante (2020) found that the spiritual practices SBNRS engage with can be referred to as 'liminals.' Liminal practice may include prayer or reading scriptures, occasionally attending religious services, or experimenting with Non-Western faiths. SBNRs may take part in alternative spiritual communities, feeling free to participate on an as-needed basis, and/or changing groups at will (Mercadante, 2020). 'Often stereotyped as 'salad bar spiritualists,' shallow or eclectic, they nevertheless do reflect on existential issues and often have spiritual struggles connected to theological dilemmas' (Mercadante, 2020, p.5). None of the other papers explicitly discussed spiritual practices that those who identify as SBNR engage with.

2.14.1.5 Summary

In answer to outcome one (how is SBNR currently being operationalised in Public Health literature), those who identify as SBNR are presented as a growing population. Within this population, there are different categories, for example secularists, atheists, agnostics, and non-affiliated. This section highlights consistency within the literature of how SBNR is defined. Therefore, critically, there is little debate as the research tends to agree with Mercadante's (2020, p.1) definition of SBNR: 'self-identified, a life stance of spirituality that takes issue with organised religion as the sole or most valuable means of furthering spiritual growth'. SBNR practices tend to be a wide variety of practices. Spirituality was seen as defined in a variety of different ways, similar to the first literature review.

2.14.2 How does the literature treat or frame the relationship between SBNR and Public Health?

To address outcome two, this section is divided into four sections concerning people who report as SBNR in relation to health: 2.14.2.1 mental health issues; 2.14.2.2 social health; 2.14.2.3 addiction issues; and 2.14.2.4 health practitioners.

2.14.2.1 Mental health issues

Four of the studies discussed spiritual struggles in the SBNR population, which had a direct impact on individuals' mental health (Baker, Stroope and Walker, 2018; Kelly and Eddie, 2020; Mercadante, 2020; Van der Tempel and Moodley, 2020). Van der Tempel and Moodley (2020) discovered participants were struggling with spiritual questions of interpersonal and ultimate meaning, which have been found to cause psychological distress. There was research to show that those who identify as SBNRs continue to seek spiritual fulfilment; this was particularly the case when experiencing negative emotions, such as fear, distrust, and anxiety (Mercadante, 2020). There was literature to demonstrate that people who identify as SBNR can struggle with an overwhelming array of life

meanings, group identities, and beliefs about such things as an afterlife, and/or ways to transcend the self (Mercadante, 2020). Spiritual struggles can also lead to confusion, despair, and negative coping such as addiction, workaholism, or depression (Kelly and Eddie, 2020; Mercadante, 2020). Collaboratively, these findings highlight the struggles some people who identify as SBNR can face and how it can negatively affect their mental health.

In the USA, many people in the SBNR population reported feeling isolated, alienated, or marginalised, especially in a country that still considers religion important (Mercadante, 2020). This was shown to cause spiritual struggles since it is difficult to know one's place in relation to others, whether there family or societal level (Mercadante, 2020). Some of those who identified as 'SBNR felt judged or pitied by their family of origin or close friends, since they no longer consider themselves either believers or belongers' (Mercadante, 2020, p.1). A couple of the studies show that some individuals pretended to still belong to a specific religion, even if they no longer believed (Mercadante, 2020). This reveals some of the potential issues around personal beliefs, highlighting not only these people's spiritual struggles, but also the fact there might be stigma attached to those who identify as SBNR. Supporting Mercadante's (2020) findings, Baker, Stroope and Walker (2018, p.49) found 'a high level of social stigma and discrimination faced by openly secular and non-religious individuals,' particularly in a highly religious environment. All these findings highlight the complexities of identifying as SBNR for some people's mental health.

2.14.2.2 Social health

Baker, Stroope and Walker (2018) and Caldwell-Harris et al. (2011), explicitly discussed social health. Cimino and Smith (2010) (in Baker, Stroope and Walker, 2018) discovered that cyber social network resources for SBNR have grown immensely in recent years. Individuals who self-identify as SBNR are much more likely to join one or even multiple secular social groups, more than individuals who identify as agnostic, humanist, sceptic, rationalist, or especially SBNR (Baker, Stroope and Walker, 2018). This was shown to provide a sense of social support for some people, which could be related to both social and mental health.

Baker, Stroope and Walker (2018) found that non-affiliated theists may be subject to persistent cognitive dissonance due to the disjuncture between their professed theistic beliefs and lack of communal belonging, and thus also have a higher risk for elevated levels of negative affect and cognition. To add to this, research by Caldwell-Harris et al. (2011) discovered that, while atheists are the most socially disliked secular category, they also have cognitive and personality strengths. Additionally, they hold social support advantages over other types of secular individuals, particularly

when embedded in a like-minded community. This was further echoed in Caldwell-Harris et al. (2011), quoting Doan and Elliott (2015) who discovered stronger atheist identification simultaneously correlates with greater stigmatisation and better physical and mental wellbeing due to being more sociable. Thus, not only do SBNR face spiritual struggles, this research indicates that some people also feel they face stigma as SBNR individuals.

2.14.2.3 Addiction issues

Three of the studies identified specifically examined the relationship between those who can be categorised as SBNR and those who have addiction issues (Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Watts, 2019). McClure and Wilkinson (2020) discovered that those who have attended substance abuse groups are more likely to identify as SBNR, as opposed to those with religious affiliations. The frequency of attendance in these groups is positively and significantly associated with being SBNR when compared to being both religious and spiritual (McClure and Wilkinson, 2020). This benefit was also echoed in Kelly and Eddie's (2020) study which established that spirituality appears to play a role in aiding recovery, particularly among those with prior treatment or 12-step histories, but women and men, and racial-ethnic groups, in particular, differ strikingly in their religious and spiritual identity and in the role this identity has played in aiding recovery. Spiritual practices were also shown

Watts (2019) also discussed spirituality among young people and discovered that spirituality was useful to those suffering from addiction issues, as it provided a sense of meaning and purpose. Spirituality was shown to give them a sense of direction, hope, and resilience (Kelly and Eddie, 2020; McClure and Wilkinson, 2020). These findings are beneficial as they highlight the positive role spirituality can play in helping people recover from addiction. However, there are limitations to these findings: they all only provide a snapshot, and the research was conducted on relevantly small populations. Therefore, the results are unlikely to be generalised to wider populations. Nonetheless, by synthesising these findings for those with addiction issues, spirituality was reported to be a positive factor for many of those who identify as SBNR.

2.14.2.4 Health practitioners

Two of these papers specifically refer to health practitioners, the need to support the SBNR population with spiritual struggles, and the stigma associated with the SBNR population (Mercadante, 2020; Van der Tempel and Moodley, 2020). Mercadante's (2020) research showed spiritual struggles, for which external help is often needed. However, it can be hard to find help that deals specifically with spiritual struggles. Bishop (2018 in Van der Tempel and Moodley, 2020) also argued that evidence-based

clinical literature regarding atheist spirituality and mental health is lacking. This was further echoed by Van der Tempel and Moodley (2020), who highlighted those non-religious individuals with spiritually themed experiences are at risk of sustaining iatrogenic harm due to inappropriate diagnosis and treatment, resulting from clinician bias and a lack of relevant education of health practitioners.

2.14.2.5 Summary

In answer to outcome two (How does the literature treat or frame the relationship between SBNR and Public Health), some studies highlight the association between mental health, social health, and addiction issues. The relationship was positive; for example, it was beneficial in helping people cope in a crisis and providing motivation. Research demonstrated there was an association between spiritual struggles and health, which at times was reported to harm some people's health (Mercadante, 2014; Mercadante, 2020). This was because those who identify as SBNR do not have a sense of belonging, which leads to mental health issues. With social health, the findings were mixed concerning health, as through online social media, some SBNR people found their strength, yet within wider society, there was more judgement. Despite this, for those with addiction issues and who identify as SBNR, spirituality provided a sense of support. In comparison to the findings from the first literature review, there was more of a negative association between those who identify as SBNR and their reported experiences of health.

2.14.3 Which methodologies appear to be most dominant in this area of research?

Similarly, to the previous literature review, there was a lack of qualitative and mixed methods research examining the relationship between the SBNR population and Public Health. It appears that most studies employed quantitative methods, as out of the ten studies, seven were quantitative studies (Baker, Stroope and Walker, 2018; Hayward et al., 2016; Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Saunders et al., 2020; Speed and Fowler, 2016; Willard and Norenzayan, 2017) and three were qualitative studies (Mercadante, 2020; Van der Tempel and Moodley, 2020; Watts, 2019). All the quantitative studies gathered data from online sources, and this included a national survey.

Two of the qualitative studies collected data via interviews (Van der Tempel and Moodley, 2020; Watts, 2019), and one qualitative study conducted interviews and two focus groups (Mercadante, 2020). These three studies specifically focused on the SBNR population (Mercadante, 2020; Van der Tempel and Moodley, 2020; Watts, 2019). The strength of the quantitative studies in relation to SBNR is that they measure the similarities and differences within populations. Mercadante, (2020) claims with the SBNR population, the positives to qualitative data help to reveal deeper meanings and further insight. A critique of these studies is that none of them conducted mixed methods research, thus they

only examine the research through one research paradigm and bring a range of findings together (discussed in more depth in section 3.3).

2.14.3.1 Summary

In answer to outcome three (which methodologies appear to be most dominant in this area of research), quantitative studies were the most dominant due to being a suitable method to shed insight on this topic, similar to the first literature review. However, it might mean the studies are missing other potential findings by only analysing one type of data, as quantitative and qualitative studies examine spirituality in different ways (Weaver et al., 2003). The benefits of exploring data separately are that they share more significant insights in their area of focus. A broader examination of spirituality and health could be undertaken by conducting a mixed method study that incorporates both quantitative and qualitative data, to help generate greater insight into the relationship between spirituality and health, particularly for those who identify as SBNR.

2.14.4 How SBNR is measured in Public Health?

As previously mentioned, there was variation over the characterisation of the SBNR population. Consequently, some of the studies are unclear in how people's beliefs were categorised or measured for the study (as identified in Table 16). Two of the papers categorised SBNR by default as they identified it as non-affiliated in a larger national survey, for example, Hayward et al. (2016) and Speed and Fowler (2016). Other studies did not ask the participants if they identified as SBNR, for example, Van der Tempel and Moodley (2020). Some studies that did address the categorisation of SBNR did ask, for example by asking participants how they defined their spiritual beliefs (Mercadante, 2020; Willard and Norenzayan, 2017). Table 16 identified the different measures noted in the ten studies. It includes SBNR measures, health measures, spiritual measures and demographic factors.

Table 16: SBNR Measures

First author*	Method type/ prominent measures	SBNR dimensions measured	Health dimensions measured	Spirituality measured	Demographic measures
Baker	Quantitative (national study)/ Likert Scales and closed tick box questions	Religious affiliation Lack of religion	Physical and mental health Frequency of physical and mental health problems Established composite metrics assessing psychiatric symptoms Spiritual wellbeing	Participation Frequency of service attendance	Gender Age Income Ethnicity
Hayward	Quantitative (national survey)/ Likert Scales and closed tick box questions	Religious affiliation	Physical and mental health Subjective health Body Mass Index Chronic health conditions	Optimism Sense of meaning in life Humility Compassion Forgiveness Gratitude	Gender Age Income Ethnicity
Kelly	Quantitative (online questionnaire)/ Likert Scales and closed tick box questions	Religious affiliation	Physical and mental health Current physical and mental status Historical participation in inpatient or residential treatment, outpatient addiction treatment, and mutual-help organisations	Level of spirituality	Gender Age Education Income Ethnicity Current marital status Dependent children Employment status
Mercadante	Qualitative (90 interviews and 2 focus groups)/ Semi-structured questions and open-ended questions	Religious affiliation Participation in spiritual practices	Spiritual struggles	Participation in spiritual practices	Gender Age Ethnicity
McClure	Quantitative (national survey)/ Likert Scales and closed tick box questions	Religious affiliation	Measure alcoholism examining engagement in substance abuse groups	Level of spirituality Spiritual wellbeing Spiritual care Engagement with spiritual practices	Gender Age Education Income Ethnicity Current marital status Dependent children Employment status
Saunders	Quantitative (online questionnaire)/ Likert Scales and closed tick box questions	Religious affiliation	Physical and mental health Health status	Spiritual wellbeing Personal meaning Transcendence Relationship to the sacred	Gender Age Education Income Ethnicity
Speed	Quantitative (national survey)/ Likert Scales and closed tick box questions	Religious affiliation	Physical and mental health Health status Frequency of physical mental health problems	Level of spirituality Engagement in spiritual practices	Gender Age Education Income Ethnicity
Van der Tempel	Qualitative (Interview data)/Semi-structured questions	Religious affiliation	Physical and mental health Health status Frequency of physical and mental health problems	Spiritual experiences Spiritual practices Supernatural belief Level of spirituality	Gender Age Education Income Ethnicity
Watts	Qualitative (interview data) / Semi-structured questions	Belief affiliation	Measures not stated	Spiritual experiences	Gender Age Education Ethnicity
Willard	Quantitative (online questionnaire)/ Likert Scales and closed tick box questions	Belief affiliation Belief they were raised with	Mental health Emotional thoughts Schizotypal illness	Spiritual experiences Spiritual practices Supernatural belief Level of spirituality	Gender Age Education Income Ethnicity

* The full list of authors and references is in Appendix 6.

2.14.4.1 Measures of SBNR

As evidenced through the literature, 'belief' tended to be measured by religious affiliation or lack of it (identified in Table 16), a lack which appeared to lead to SBNR status (Baker, Stroope and Walker, 2018; Kelly and Eddie, 2011; Mercadante, 2020; Saunders et al., 2020; Willard and Norenzayan, 2017). Religious affiliation was measured by asking for a response using the Likert scale and closed tick box questions about the participant's belief. For example, in Kelly and Eddie's (2020) study, the participants were asked about their beliefs using a Likert scale. For each dimension, participants reported the extent to which they considered themselves spiritual or religious on a Likert scale from 1 (not spiritual/religious at all) to 4 (very spiritual/religious). They also reported on a Likert scale from 1 (have not helped at all) to 5 (made all the difference). McClure and Wilkinson (2020) similarly phrased the question as follows: 'which category most fits your personal belief?' The answers to this question were as follows: neither religious or spiritual, religious but not spiritual, spiritual but not religious, or both. Critically, the dimensions of SBNR seemed to be related to 'lack of belief', 'lack of belonging', and 'lack of religion' (Baker, Stroope and Walker, 2018; Saunders et al., 2020), and engagement in spiritual practices (Mercandate, 2020).

Baker, Stroope and Walker's (2018) research specifically examined atheists and non-atheists. To measure the participants' beliefs, they asked the participants which one statement came closest to their personal beliefs about God. Two response options were: "I am an atheist" and "I don't know, and there is no way to find out", which were used to create categories for atheists and agnostics, respectively. This response is given priority over religious affiliation, to the extent that non-theists who also report having an affiliation would be classified as atheist or agnostic. The overall literature review indicated, that there were no specific validation tools to measure SBNR, and how participants identify their beliefs tends to be phrased as a closed tick box question. The qualitative studies by Mercandate (2020) and Watts (2019) tended to discuss with the participants their spiritual struggles and the way this was the case.

2.14.4.2 Measures of spirituality

Within the quantitative SBNR literature, spirituality tended to be measured using a Likert scale. The dimensions of spirituality included dimensions of 'spiritual experiences', 'spiritual practices', 'supernatural beliefs', and 'levels of spirituality'. In Willard and Norenzayan's (2017) study, dimensions of spirituality were measured using adaptations from the Life Orientation Test. The dimensions of spirituality included spiritual wellbeing, attendance (more than weekly, weekly, monthly, or never),

and organisational and non-organisational spiritual activities (Baker, Stroope and Walker, 2018; Willard and Norenzayan, 2017). This was also echoed in the first literature review (section 2.6.4.3). Saunders et al. (2020) note that spirituality was measured by its personal meaning to people, transcendence, and relationship to the sacred. In Mercadante (2020), spirituality was measured as more of an open question by asking the participants what they thought spirituality meant to them.

2.14.4.3 Measures of health

In a similar way to the first literature review, the role of 'health' in the studies focussed upon in this second review was measured by either structured questions (qualitative) or a Likert scale (quantitative). The dimensions of health that were measured were revealed as prominent aspects of people's physical and mental health. For instance, Hayward et al. (2016) measured physical health symptoms, including fitness and lifestyle questions such as 'how often do you exercise?'. Willard and Norenzayan (2017) used Baron-Cohen's (2004) Empathy Quotient to measure mental health, utilising questions such as whether the individual often 'find(s) it difficult to judge if someone is rude or polite.' Schizotypal (a mental health illness) was measured using the Schizotypal Personality Disorder scale (Raine, 1991 in Willard and Norenzayan, 2017). On the other hand, Baker, Stroope and Walker (2018) found that the frequency of health problems was assessed by using measures from questions that asked respondents to report how often during the past 30 days: 1) their physical health was not good; 2) their mental health was not good; 3) pain made it difficult to perform usual activities; 4) they felt sad, blue, or depressed; or conversely; 5) they felt very healthy and full of energy. The available choices in terms of answers to these questions were: none, 1–10 days, 11–20 days, 21–29 days, and all 30 days. These particular health measures were also discussed in Willard and Norenzayan (2017) paper, demonstrating a variety of health measures, depending on the desired outcome.

2.14.4.4 Demographic factors

All the studies identified measured similar demographic factors, including age, gender, income and ethnicity (identified in Table 16) (Baker, Stroope and Walker, 2018; Hayward et al., 2016; Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Saunders et al., 2020; Speed and Fowler, 2016; Willard and Norenzayan, 2017). Some of the studies particularly examined income (Baker, Stroope and Walker, 2018; Hayward et al., 2016; Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Saunders et al., 2020; Willard and Norenzayan, 2017), marital status (Kelly and Eddie, 2020), educational attainment (McClure and Wilkinson, 2020), or whether the participants have any children (McClure and Wilkinson, 2020). These results were acquired by using closed tick box questions; in relation to gender, the

studies tended to ask: 'do you identify as: 'Male', 'Female' or 'Other'' (Speed and Fowler, 2016; Van der Tempel and Moodley, 2020).

Kelly and Eddie's (2020) study drew upon the structure of the demographic data from the Growth from Knowledge Survey, and existing knowledge panel data. Examples of how some of these questions were phrased are as follows:

- Whether household income was less than $25,000; or was in the following brackets: $25,000-$49,999; $50,000-$74,999; $75,000-$99,999; $100,000 or greater.
- An individual's marital status; for example whether they are widowed, divorced, separated, never married, or living with a partner
- Whether the individual is currently employed.

These (tick box) questions were also noted in both Kelly and Eddie (2020) and Willard and Norenzayan (2017) paper. However, Willard and Norenzayan (2017) found that income was not different for the non-religious and the SBNR population, and that there were no significant effects on educational attainment.

Kelly and Eddie's (2020) findings revealed a higher percentage of spiritual Black Americans compared to other races. Kelly and Eddie found that, regarding White participants, 'there was a clear declining relationship in the importance of the role that both spirituality and religiousness had played in the recovery (from addiction); for Black participants, it was the opposite, as only a very small proportion reported that 'spirituality or religion had not helped at all' (Kelly and Eddie, 2020, p.121). Kelly and Eddie (2020, p.121) further discuss that 'the exact mechanisms through which religion and spirituality may play such an important perceived role in addiction recovery' are unclear. Thus, when it comes to examining and measuring demographic factors and the characteristics of those who identify as SBNR, the effects of spirituality might differ between ethnicities. Furthermore, Kelly and Eddie (2020, p.121) found that men and women also differed, with 'women reporting that spirituality and religiousness played a more important role in aiding their recovery than did men' the study noted that the exact reasons for such differences are unclear, and should be explored in more detail.

2.14.4.5 Summary

In answer to outcome four (how SBNR is measured in Public Health), there was variation over how SBNR is measured within the literature. This can also be linked to the categorisation of who comes under the term of SBNR. Belief tended to be measured by lack of religious affiliation. Health was measured by looking at different dimensions of health, such as physical and mental health. This

variation was also found with regards to how spirituality was defined, as the dimensions that made up these variables, such as spiritual wellbeing and level of affiliation and practices, were measured. Demographic measures tend to be the standard questions asked within research, while some studies just asked a few more demographic variables than others, such as education and marital status. The only difference explicitly noted in the demographic factor was to do with the participants' ethnicity. Consequently, the findings are consistent with previous literature findings.

2.15 Limitations

While there has been some research to advance the understanding of the connections between SBNR and aspects of people's health, there are also several limitations. None of the studies were conducted in the UK (which might categorise SBNR differently); therefore, it is difficult to know how useful these studies are when applied to a UK population. Despite the comprehensive and systematic search and screening methods employed, some studies that met the inclusion criteria may not have been identified (Clarke and Crane, 2018; Hai et al., 2019). There is also the matter of researcher bias, as the interpretations are my own and have not benefited from the reflective thoughts of other researchers (Grant and Booth, 2009). Some other limitations pertain to the language restriction in the literature search, as studies may exist in languages other than English (Braam and Koenig, 2019). Despite these limitations, the critical appraisal of the literature was undertaken, and the studies were deemed to be of high quality. This research brings together literature on those who identify as SBNR in relation to health, which might provide insight for future studies.

2.16 Summary and outcomes

In answer to the second PEO for this literature review, there have been a handful of respectable and robust studies carried out on specific aspects of SBNR in relation to health. The presented research demonstrates that the findings on the SBNR population and health were relatively mixed. SBNR can prove damaging to individuals' health due to associated spiritual struggles and stigma. However, holding a spiritual belief was also found to be useful for those with addiction issues. There was also some online social support for those who identified as SBNR, which could be linked to the characterisation of SBNR. These findings highlight the struggles some people who identify as SBNR can face and demonstrate how it can negatively affect their mental health. This second literature review underscores the gap in terms of the limited research on those who identify as SBNR and how this could potentially impact health in the UK. Although those who identify as SBNR are a growing population, there was not a significant amount of rigorous research in this area.

Predominately quantitative studies were used to explore SBNR and health literature; consequently, many measures were conducted using Likert scales and closed questions. In this light, belief tended to be measured by lack of religious affiliation, whereas health was measured by looking at its different dimension, such as physical and mental health. This was also true for the demographic factors; the findings of previous studies indicate there might be differences between genders and ethnicity of those who identify as SBNR. This can also be linked to how SBNR was categorised as this varied within the studies. Importantly, the qualitative studies tended to explore why the participants held certain beliefs and focused on factors such as why individuals reported to be undergoing spiritual struggles.

2.17 Definitions proposed within this thesis

For this thesis, there is a need for a clear distinction between 'spirituality', 'religion', 'SBNR', and 'spiritual health', and also between 'health' and 'Public Health'. This next section provides a critique and justification for the definitions proposed, an assessment of their weaknesses and limitations, a recognition of the bias associated with them, and an assessment of the impact of those biases on this thesis. Great consideration was given as to the best place to position these distinctions within this thesis, as it was an integral part of the study. It was decided that the most appropriate location was after the literature review and before the methods chapter.

When it comes to distinguishing between and defining key terms in the field of Public Health, there is a tendency to look at well-established Public Health institutions, such as the WHO or Public Health England, and to employ their standard definitions. This is because they tend to draw on robust evidence, conduct a critical analysis of the existing literature, and apply this knowledge to Public Health matters (Brownson et al., 2017; Tolley et al., 2016; Sørensen et al., 2012). However, when this is not provided (or appropriate), key terms are defined by analysing how they are presented within the literature.

2.17.1 Spirituality

In light of the relevant literature, this study argues that definitions need to be dynamic and constructed for the context in which they will be applied; this is particularly true for spirituality. As demonstrated by the previous two literature reviews (and the introduction of this thesis), spirituality was defined differently in various contexts and settings. Clarke (2013) suggests that the key to defining spirituality is understanding what spirituality means for the individual. Indeed, there has been an over-emphasis on producing a definition of spirituality and less consideration around making it useful for practice (Gordon et al., 2018; McSherry et al., 2004). Narayanasamy (2001) proposes that individuals'

perceptions of spirituality are so diverse that it is unrealistic and idealistic to provide one single definition. Some researchers raise the issue that, if the definition of spirituality is too broad, it may become vague and over-inclusive (Clarke, 2009). However, Swinton and Pattinson (2010) argue that being vague about defining spirituality may be its strength and value in practice as, for some, it is individualistic. Critically, these variations and difficulties within the literature can make it harder for spirituality to be operationalised within Public Health practice and research. As a result, defining spirituality for this thesis was vital. At the early stages of this study, a Concept Analysis (presented in Appendix 7) was conducted to define spirituality. The purpose of this analysis was to explore how spirituality is defined within health. This concept analysis facilitated a way to deal with the ongoing challenges of operating the term spirituality, thus enabling it to be applied to this thesis.

2.17.1.1 Concept analysis

The Concept Analysis model by Walker and Avant (2014) was employed as it appeared to be the most influential model used in health disciplines to demonstrate how a concept was defined (Hussey and Smith, 2008; Metaxiotis and Psarras, 2005). It should be recognised that there are other concept analysis models, such as Roger and Knafl (2000) and Wilson (1969). Walker and Avant (2014) was explicitly chosen as it is often used and considered the standard practice used to define a specific term. The Walker and Avant (2014) model has reduced Wilson's thirteen-step model to eight steps (Nuopponen, 2010), and the framework is generally believed to be a relatively straightforward process to follow. By following Walker and Avant's (2014) eight-step process (presented in Appendix 7), the following definition of spirituality was reached:

'That which seeks to transcend the self and find meaning and purpose; this could be achieved through connection and engagement with others, the surrounding environment or oneself.'

This definition is not absolute; however, it helped operationalise spirituality to guide the rest of this thesis. This definition is compared to the previous literature found in the previous literature review in section 2.17.1.2. The strength of this definition is that it was developed by the concept analysis, and it was attained in a transparent and structured way by examining definitions from other studies; it can be seen as broad, therefore encompassing a wide range of factors. It was intended to be comprehensive enough to allow for diversity in thought and multiple discussions, thereby promoting accessibility to all. The concept analysis highlighted these attributes of spirituality:

- Connectedness: The link with self, others, nature or a higher being.
- Holism: A multi-dimensional feature affecting every part of a person's life.

- Self-actualisation/self-acceptance: A person feels complete in relation to their life.
- Multidimensional: Several dimensions or aspects.
- Faith: A belief in and an assent to something greater than the self.

Other attributes of spirituality noted in the concept analysis included: love, happiness and hopefulness (discussed in more depth in Appendix 7). Although the current study does not include 'religion', the original concept analysis was relevant to the current research because it provided a foundation for the current study. However, this thesis has purposefully excluded religion as it focuses on an SBNR population. As stated previously, those who identify as SBNR tend to take issue with organised religion (Hastings, 2016; Mercadante, 2014; Smith, 2020), providing an explanation as to why these elements have been omitted from this study.

2.17.1.2 Comparison against the previous literature

Throughout this study, it was critical to define spirituality in accordance with the concept analysis, and compare this to the definitions found in the two literature reviews, specifically those provided in Table 6 and Table 15, which were then merged to form Table 17, making it less challenging to compare the definitions to those found in the concept analysis.

Table 17: Definitions used to describe spirituality within both literature reviews

First Literature review		Second Literature review	
First author*	**Definition of spirituality**	**First author*****	**Definition of spirituality**
Braam Gijsberts Gonçalves Gordon Hosseini Liefbroer Thune-Boyle Wang Weaver	Not specifically defined. **	Baker Hayward McClure Speed Baker Hayward	Not specifically defined. **
Hai	The universal and fundamental human quality of searching for meaning, wellbeing, and profundity through connections with oneself, others, and the universe, and religion as an institutionalised system of beliefs, values, and practices oriented towards spiritual concerns and transmitted over time by a community.	Kelly	Broader recognition of powers greater than oneself and a broad array of associated beliefs and practices that may or may not fit within the realm of different religions and are more likely to be self-defined and self-governed.
Hulett	A subjective experience of the sacred which refers to an emotional connectedness or relationship with God or the transcendent beyond the self.	Mercadante	Personal, heartfelt, and authentic.
Lewis	Individualistic, less visible, more subjective, less formal, and emotionally oriented.	Saunders	A dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred.
Milner	Transcend ordinary physical limits of time and space, matter, and energy.	Van der Tempel	Self-transcendent sense of unity; intense positive affect; and a sense of revelation of meaning and purpose.
Monod	A sense of transcendence beyond one's immediate circumstances, and other dimensions such as purpose and meaning in life, reliance on inner resources, and a sense of purpose and life satisfaction.	Watts	A personalised attempt to re-enchant what is experienced as a disenchanted world.
Moreira	The attribution of meanings to life, which is not synonymous with religious doctrine, can be considered as a philosophy of the individual and a resource of hope.	Willard	The individual experience of the supernatural.
Schreiber	Meaning in life, spiritual wellbeing, and spiritual integration.	Van der Tempel	Self-transcendent sense of unity; intense positive affect; and a sense of revelation of meaning and purpose.
Selman	Beliefs, values, and practices that relate to the search for existential meaning, purpose, or transcendence, which may or may not include belief in a higher power.		
Smith-MacDonald	Beliefs, values, behaviours, and experiences related to ultimate meaning, often involving deities and dogma formulated by faith groups or institutions over time.		

* The full list of authors and references can be found in Appendix 3.
** All papers that did not provide a specific definition of spirituality were merged.
*** The full list of authors and references can be found in Appendix 6.

Within the definitions, as illustrated in Table 17, particular words repeated themselves, such as 'connection' (Hai et al., 2019; Hulett and Armer, 2016), and 'beliefs' (Hai et al., 2019; Selman et al., 2011; Smith-MacDonald et al., 2017). Furthermore, similar phrases could be linked, such as 'experience of the supernatural' (Willard and Norenzayan, 2017) and 'self-transcendent' (Van der Tempel and Moodley, 2020) which could be seen as interchangeable terms (Hulett and Armer, 2016; Milner et al., 2020; Selman et al., 2011). Supporting this specific definition, a number of these words were also reflected in the concept analysis, such as 'connection' and 'transcendence'. One term in particular which arose in the literature review definitions of spirituality and was not highlighted in the concept analysis is the term 'belief'. This term, however, may be seen as similar to 'faith', which the concept analysis described as 'a belief in and assent to something greater than the self'.

The definition of spirituality utilized in the concept analysis could be considered similar to other definitions identified in the literature review, such as Hai et al.'s (2019): 'The universal and fundamental human quality of searching for meaning, wellbeing, and profundity through connections with oneself, others, and the universe, and religion as an institutionalized system of beliefs, values, and practices oriented towards spiritual concerns and transmitted over time by a community'. On the other hand, Monod et al. (2011) defined spirituality as 'a sense of transcendence beyond one's immediate circumstances, and other dimensions, for example, the purpose and meaning in life, reliance on inner resources, and a sense of purpose and life satisfaction'. Although there were not any outstanding differences between the definitions, some utilised different terms, whilst others used broader definitions. Yet overall, the terms generally support the definitions proposed in the concept analysis.

It could be argued that some of the definitions presented build on the existential experience of spirituality, which can be a source of purpose and meaning for many individuals. This study has thus far evidenced that the quest for a coherent definition of spirituality remains a challenge not only for Public Health, but across all healthcare professionals (Oman, 2018). In this light, this studies critical analysis and comparison of the various descriptions of spirituality in the literature has highlighted various similarities across the board. Therefore, it seems appropriate that the concept analysis definition of spirituality was utilised for this research.

2.17.1.3 Critiques of this definition

There are several limitations of this concept analysis definition, due to the fact that spirituality is contextual and widely influenced by factors such as a person's worldview, personal experiences, and the socio-political context in which they live (Clarke, 2013; Greenstreet, 2001; Park, 2007). Arguably, due to the subjective, idiosyncratic nature of a person's spirituality, it is not possible to develop one

unified definition for use across all professions and cultures (Martsolf and Mickley, 1998; Swinton, 2001). Despite a range of definitions relating to spirituality, applying them to healthcare practice remains challenging, due to the fact that such definitions are not always meaningful for healthcare professionals, nor do they always meet patients' needs and expectations (Gordon, Kelly, and Mitchell, 2011; Johnston and Mayers, 2005; McSherry et al., 2004; Unruh, Versnel and Kerr, 2002). Moreover, further limitations of this definition are presented Jones (2016, p.35), who explores how the issue of definitions remains similar across all professional groups, raising critical questions, such as 'whether individuals experience spirituality with or without a deity, and whether spirituality is a personal philosophy, enabling individuals to interpret their life circumstances, or if spirituality is a concept that can meaningfully be defined'.

Another potential factor to be noted is the ways in which personal bias may have affected the ways in which the concept analysis was undertaken; as it was conducted by myself, the concept analysis could be seen to reflect my definition of spirituality and not others. This limitation could potentially influence the thesis and the consequent results which might not be generalisable to broader populations. Despite all these limitations, this definition was useful to describe spirituality (rather than define), and it helped inform the rest of this study. How spirituality is described by an SBNR in the UK will be further explored in this thesis.

Some ethical concerns must also be considered when operationalising spirituality in Public Health. This is true for both research and practice. For example, Public Health practitioners must not cross boundaries, and it is important to ensure that spirituality is discussed in a way that promotes health and is not detrimental to it (Oman, 2018). Rogers (2016, p.42) further proposes a 'concern about not imposing one's values that relate to a fear of projecting one's own belief onto a patient, which is seen as an abuse of the relationship'. These anxieties could also be true when operationalising spirituality among health practitioners, which is potentially one of the reasons why it has not been fully considered in Public Health. It could be argued that an increased discussion of this topic raises certain ethical and moral concerns over its focus. However, this study has thus far demonstrated two important factors that counteract this: firstly, it is evident that it remains important to individuals and communities to discuss their beliefs concerning health, and secondly, there is a crucial requirement for an agreed language through which to discuss the importance of spirituality (Greenstreet, 2006; Richards and Potts, 1995). The current study makes important steps to address this gap.

2.17.1.4 Summary

It has become clear through the preceding analysis that defining spirituality remains a contentious and problematic topic. Indeed, analysing how individuals perceive spirituality is a challenging process that requires further work. The study has demonstrated that an overriding concern in defining spirituality is that understanding it must be congruent with the individual personal experience, worldview, and culture (Ellis and Narayanasamy, 2009), and ultimately, an individual's spirituality should be considered an integral part of health (Como, 2007; Juškienė, 2016; Myers and Williard, 2003). Taking all the proceeding findings into account, the concept analysis crucially developed a working definition of spirituality, namely:

'That which seeks to transcend the self and find meaning and purpose; this could be achieved through connection and engagement with others, the surrounding environment or oneself.'

The limitations of this definition have been recognised, and the effects on the results of this study are acknowledged. Despite these critiques, this definition can be seen as encompassing, generally supported by existing and useful for this piece of research.

2.17.2 Religion

The term religion is defined as 'an institutional affiliation that is less about unique individual experiences and more about shared doctrines' (Willard and Norenzayan, 2017, p.183). This definition was considered more inclusive than the others identified in the literature review, such as Mercadante's (2020), which defined religion as 'external, structured, and non-essential'. Willard and Norenzayan's (2017) definition was chosen as it helped to present religion as a distinct concept from spirituality, highlighting the person-centredness of religion, and it can be seen as a contemporary and relevant definition.

A critique of this definition could be that it is too broad to be measured within Public Health research. Different variables can be seen as being encompassed within the definition, and it is not definitive. It should be noted that within the literature, there is no single definition of religion that has emerged as the standard (Hall, Meador and Koenig, 2008). However, people who identify as religious might disagree with the definition because it does not represent their personal beliefs, which could be seen as a bias. This definition could also be interpreted as being oversimplified. A limitation of applying this definition to this study means the results might not be generalisable to the whole population. Nevertheless, this approach to defining religion was helpful as it is separated explicitly from spirituality, recognises people's individuality. As a result, it was applied to this thesis.

2.17.3 SBNR

SBNR was defined as 'self-identified, a life stance of spirituality that takes issue with organised religion as the sole or most valuable means of furthering spiritual growth' (Mercadante, 2014; Mercadante, 2020). This definition was chosen because it is the commonly accepted definition among those who identify as SBNR, as well as the definition used within the literature (Fuller, 2001; Mercadante, 2014; Mercadante, 2020). However, there are variations between those who identify as SBNR and how SBNR population is characterised (as discussed in section 2.14.1.1) (Mercadante, 2014; Parsons, 2018). One of the critiques of this definition is that it has drawn on literature from the USA; thus, the USA and the UK's definitions and categorisations of SBNR might differ culturally. There is also a blurring of the boundaries of the different groups within and around the SBNR population (Mercadante, 2014; Parsons, 2018).

As discussed, SBNR is a growing phenomenon, so the definition and characterisation might change over time (Fuller, 2001; Mercadante, 2014; Mercadante, 2020). The definition also relies on individual perception and categorisation of people's beliefs. This definition could affect this study as it highlights SBNR's uniqueness; therefore, it might be challenging to generalise the findings to a broader population. Another limitation of this definition is that it might not encapsulate all those who define themselves as SBNR. Despite these criticisms, this was deemed the best approach to define the SBNR population for this study.

2.17.4 Health

Good health is necessary to carry out daily tasks and enable people to live to the full (Ogden, 2012; Scriven, 2017). Perceptions of health can vary across the lifespan and are influenced by a range of factors, including individual experiences, socialisation, physical environment, and culture (Ogden, 2012; Scriven, 2017; WHO, 2021). People's personal experiences and subjective beliefs can shape their understanding of health and the meanings attached to it (Ogden, 2012; Scriven, 2017; WHO, 2021).

The most widely used definition of health comes from the WHO (1946), which defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity'. Robinson (2021) argues that the WHO description is significant because it marks the moment that health was formally and internationally recognised as being positive and holistic, as well as incorporating wellbeing. The pursuit of wellness is an essential goal for many people (Lyubomirsky, Sheldon and Schkade, 2005) and the WHO is increasingly emphasising wellness as a theme of health (DeGargino, 2004). However, the WHO description has been criticised for being too idealistic and broad to identify practical priorities successfully to measure health (Day, 2013; Naidoo and Wills,

2016). It has also been argued that the WHO definition has become counterproductive, 'as it declares a person with chronic diseases and disabilities definitively ill' (Huber et al., 2011, p.343).

There are many models and approaches to health within the health discipline, particularly in Public Health (Naidoo and Wills, 2016; Scriven, 2017). Generally, they are divided into three categories: biomedical, social, and health promotion models. A biomedical model of health focuses on a physical or biomedical aspect of disease and illness (Larson, 1999). 'Social models of health recognise that people's health is influenced by a wide range of individual, interpersonal, organisational, social, environmental, political, and economic factors' (Yuill, Crinson and Duncan, 2010, p.14). There are also health promotion/holistic models of health, which are an integrated approach to healthcare that treats the 'whole' person, not merely symptoms and disease (Larson, 1999).

Engel in 1977 developed the bio-psycho-social-spiritual approach to health (Adler, 2009; Frankel, Quill and McDaniel, 2003). This method of describing health is widely used in Public Health and psychology to investigate, understand, and measure health (Leukefeld and Leukefeld, 1999). This approach claims a person's health depends upon a range of factors: biological, psychological, social, and spiritual (Frankel, Quill, and McDaniel, 2003). Scriven (2017, p.8) incorporated elements of a bio-psycho-social-spiritual approach to health, as well as adapting the WHO definition of health. Scriven (2017, p.8) incorporated elements of a bio-psycho-social-spiritual approach to health, and also adapted the WHO definition of health. Scriven (2017, p.8) has decompartmentalised the WHO definition to include the following six dimensions:

- Physical health is concerned with the mechanistic functioning of the body.
- Mental health is the ability to think clearly and coherently.
- Emotional health is the ability to recognise feelings and express them appropriately, such as coping with stress, tension, depression and anxiety.
- Social health is the ability to make and maintain healthy relationships.
- Societal health is how well a society offers every person an equal chance to gain access to the goods and services vital to being able to function as a member of a given society, such as making sure everybody has equal opportunities, fair policies and all have access to healthcare.
- Spiritual health for some people relates to religious beliefs and practices: for other people, it is to do with personal creeds, principles of behaviour and a way of achieving peace of mind and being at peace with oneself.

The identification of these different aspects of health is a useful application in raising awareness of the complexity and the holistic nature of health. Mental health can be distinguished from emotional and social health, although there is a close relationship between the three types of health (Scriven, 2017). Regarding societal health, 'a person's health is inextricably related to everything surrounding that person. It is impossible to be healthy in a sick society that does not provide the resources for basic physical and emotional needs' (Scriven, 2017, p.8). In practice, it was evident that dividing people's health into different areas can impose artificial divisions and unhelpful distortions. At the same time, these dimensions recognise that health is a dynamic state, that each person's potential is different, and that thus their needs therefore vary.

A positive characteristic of Scriven's (2017) approach to health is that the term was viewed as incorporating wellbeing, contributing to the notion of holistic health. This definition of health is drawn on for this thesis, as it has much to offer Public Health practitioners and individuals. It recognises health as a dynamic state, treating each person's potential as different, and each person's health needs as a variable. Efforts towards optimum health are both an individual and a societal responsibility (Scriven, 2017). It involves empowering people to improve their quality of life. However, a limitation of using this definition is that it might be unrealistic; in practice, health is more complex than this. A bias of this approach is that health can be seen as too idealistic and not recognising the complexity of its relationship to people's health. This will potentially affect this thesis because it divides health into sections and, for some people, it might be unrealistic to achieve full health. Also, those with illness (such as those with social anxiety) might struggle to achieve every element of health. This limitation and bias of this research needs to be kept in mind when examining and measuring health. Despite these limitations, the Scriven (2017) dimensions of health were chosen as they encompass both the WHO definition and wellbeing; it is a well-recognised definition and, for this thesis, it was the most appropriate way to measure how spirituality affects aspects of people's health, thus enabling a person-centred approach based on evidence-based practice.

2.17.5 Spiritual health

'Spiritual health for some people relates to religious beliefs and practices: for other people, it is to do with personal creeds, principles of behaviour and a way of achieving peace of mind and being at peace with oneself' (Scriven, 2017, p.8). This is the definition used to define spiritual health in this thesis, because it is part of the definition of health being applied; therefore, there is consistency. Some researchers raise the issue that if the definition of spiritual health is too broad, it may become vague and over-inclusive (Clarke, 2013). However, (again) Swinton and Pattinson (2010) advocate that being vague about defining spirituality, thus also spiritual health, may be its strength and value in practice,

as for some spirituality is seen as personal to the individual. A limitation of this definition is that it is more difficult for spiritual health to be understandable in order to be operationalised within Public Health practice. A bias of this approach is that there are many definitions of spiritual health, but this is the approach that has been chosen for this thesis. This might be due to an alignment with my own beliefs about spiritual health and might not represent others' understanding of spiritual health. However, acknowledging this bias helps to minimise it because the bias has been recognised. Thus, it can be accounted for. After an assessment of this approach, this definition was found to be useful because it fits with the definition of health being applied and can also be adapted to the situation in which it is being operationalised.

2.17.6 Public Health

For this thesis, Public Health was defined as 'the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society' (Acheson, 1988; WHO, 2019). It focuses on the social, economic, and cultural factors that shape the health of populations (Scriven, 2017; WHO, 2019). This definition has been criticised due to being too reductionist in its approach (Frank, 1984) and embedded in reductionist thought (Raphael and Bryant, 2002). Another limitation is that it is very structurally focused. Therefore, it can be challenging to apply it in practical terms to individuals. A bias associated with this approach is that it focuses on a population level and less on individuals and small communities, which is what is increasingly being encompassed under the umbrella of Public Health. This may impact this study as the focus is on Public Health in a biomedical way, when Public Health is trying to be more holistic. Despite these issues, the strength of this definition is that it could be seen as spatial, with multiple layers, recognising individuals within the other layers of Public Health. It is internationally recognised as the definition of Public Health, and its key elements underpin the field of Public Health (WHO, 2021). As this definition provided the foundations of Public Health and its values it was decided the most appropriate for this thesis.

2.17.7 Summary

Although the definitions proposed are not without critique, these definitions do provide a clear distinction between the terms utilised for this study. This section provided critiques and justification for the proposed definitions, an assessment of their weaknesses and limitations, and a recognition of their bias. Recognising these issues with these definitions will facilitate a more robust and objective thesis.

2.18 Chapter summary

Two literature reviews were conducted in this chapter. Both of these reviews identified a sizeable body of research studies that have examined different aspects of spirituality. This chapter has also highlighted the definitions proposed in this thesis. The main findings of the results highlight that the literature demonstrates an association between spirituality and aspects of people's health (particularly physical and mental health). Spirituality was generally shown to help people and give them meaning and a sense of purpose which was reported to improve an aspect of their health. However, particularly in the second literature review, spiritual beliefs were shown to have a more mixed effect on some people's health, based on the context, circumstances, and setting of the individual's relationship and spirituality. The findings of the second literature review helped to identify literature on those who identified as SBNR. It further highlighted some of the more negative connotations in relation to spirituality and health, such as spiritual and identity struggles, which for some were reported to lead to poor mental health. It was also useful to highlight the areas where this topic would benefit from further investigation. In addition, this chapter has provided the operational definitions that shall be applied within this thesis.

Based on this in-depth examination of the literature, there are three main areas of further research: first, there is a need to strengthen the evidence base on the role of spirituality within Public Health, particularly on the elements of spirituality that are affecting health. This can include exploring spirituality in a wide range of contexts and settings (such as the general population). Secondly, to examine how, the precise way in which spirituality can affect health for those who identify as SBNR, as this was an area where there seemed to be a gap in the literature. Thirdly, a particular focus on the UK would be useful to see how the findings compare to other countries. This thesis will explore the gaps highlighted in this literature review and establish whether this study supports or disputes existing evidence from a Public Health perspective. The main question of this thesis was:

'How do self-identified healthy people who also identify as Spiritual but Not Religious report the relationship between spirituality and different dimensions of their health?'

Many studies have focused on spirituality in unhealthy populations; this study explores spirituality in a healthy population. Spirituality remains an elusive concept and one that is difficult to define, but it has nevertheless gained prominence in healthcare literature over recent years (MacKenzie, 2017). The literature has identified that investigation of spiritual factors in health is warranted and relevant, especially as many spiritual practices and/or aspects do not seem to have been evaluated, such as

among those who identify as SBNR. For all these reasons, this study will focus on adults who live in the UK to allow conceptualisation and depth.

The overarching aim of this thesis will be to explore public beliefs about the impact of spirituality on different dimensions of health in the UK population. For my contribution to the field of Public Health, I explored people's reported beliefs about the relationship between spirituality and health in the UK. Researching this relationship may lead to some reported benefits in terms of people's health as well as minimising potential harm within health, through a better understanding of and attention to people's spiritual needs.

Chapter Three

Methods

3.0 Introduction

The following chapter presents the research methodology and methods related to this PhD thesis. As the literature review identified, there has been a limited number of studies in the UK that consider the relationship between people's spiritual beliefs and health. An exploratory study was undertaken to research this topic more in-depth. From a Public Health perspective, the purpose of this thesis was to generate new information which could help inform future Public Health practice by providing new insight. By disseminating the findings (discussed in section 6.3), it was hoped that Public Health practitioners might develop a deeper understanding of how spirituality is perceived to impact aspects of some people's health.

This chapter presents the aim and objectives of this thesis and an overview of philosophical stances, followed by the rationale for adopting a pragmatic approach, and using mixed methods study design. Alternative quantitative and qualitative approaches are outlined, with reasons for rejection, data collection methods (a questionnaire and interviews) are described, and the design and dissemination strategy is presented. It also includes a discussion on the sample size, the quality criteria of this research, procedures, ethical considerations, data analysis, reflexivity, and the chapter summary.

3.1 Aim and objectives

To address the gaps identified in the existing literature, the overall aim of this thesis was to answer the following research question:

How do self-identified healthy people who also identify as Spiritual but Not Religious report the relationship between spirituality and different dimensions of their health?

This aim was broken down into five objectives:

1. To ascertain the participants' self-perception as to whether they were healthy or not.
2. To explore the definition of spirituality from the participants' perspective.
3. To explore the spiritual practices of the participants.
4. To explore the reported relationship between the participants' spiritual beliefs and their health.
5. To explore whether demographic factors (specifically gender, age, education, income, ethnicity, and place of birth) can impact spirituality and the participants' health.

These objectives were developed to help address the overall aim of the thesis. They were established by following Van De Water's (2017) six stages of developing research objectives: 1) they should be presented briefly and concisely; 2) they should be presented in logical sequence; 3) they should be realistic; 4) they should be phrased in operational terms; 5) they should use action verbs that are specific enough to be evaluated or measured; 6) they should be flexible, applicable, and beneficial once the study work begins. This approach helped develop appropriate research questions in line with the gaps identified in the literature review.

3.2 Overview of philosophical stances

This research's philosophical underpinnings (also known as research paradigms) refer to how people understand and make sense of the world (Creswell and Plano Clark, 2011). Creswell and Creswell (2018) state that there are primarily four research paradigms within health research: Post positivism, Constructivism, Transformative and Pragmatism (illustrated in Table 18). These four research paradigms generally are adopted in different contexts, depending on the research type. Creswell and Creswell (2018) have created a typology of different approaches to conducting a study and the underlining assumptions. Table 18 summarises the different paradigms and ontologies, epistemology, methods and the strengths and limitations of each approach.

Table 18: Summary table of different approaches to research

Prominent Research Paradigm	Ontology	Epistemology	Method	Question	Strengths	Limitations
Post positivism: A philosophical stance that highlights the importance of objectivity and the necessity to study observable components.	Hidden rules govern the teaching and learning process.	Focus on reliable and valid tools to uncover rules.	Quantitative	What works?	Findings can be generalised if the selection process is well-designed, and a sample represents the study population. Relatively easy to analyse. Data can be very consistent, precise, and reliable.	Related secondary data is sometimes unavailable, or accessing available data is difficult/impossible. Difficult to understand the context of a phenomenon. Data may not be robust enough to explain complex issues.
Constructivism: An interpretive framework whereby individuals seek to understand their world and develop meanings corresponding to their experience.	Reality is created by individuals in groups.	Discover the underlying meaning of events and activities.	Qualitative	Why do you act this way?	Complement and refine quantitative data. Provide more detailed information to explain complex issues. Useful for gathering data on sensitive subjects.	Findings usually cannot be generalised to the study population or community. More difficult to analyse; does not fit neatly in standard categories. Data collection is usually time-consuming.
Transformative: A research enquiry needs to be intertwined with politics and a political agenda.	Society is rife with inequalities and injustice.	Helping to uncover injustice and to empower citizens.	Ideological review, civil actions	How can I change this situation?	Useful for political change.	Ignores the question of the feasibility of alternative systems and the prevalence of structures that generate both good and bad effects.
Pragmatism: The notion that knowledge claims arise out of actions, situations, and consequences rather than antecedent conditions.	Truth is what is useful.	The best method is one that solves problems.	Mixed methods	Will this intervention improve learning?	It helps to provide a complete picture of a research problem. It is a means to incorporate qualitative and quantitative study.	Greater cost of time and money. Not all audiences are open to mixed methods studies. Training is required in both quantitative and qualitative research methods.

Table adapted from Creswell, J. and Creswell, J. (2018) *Research Design: Qualitative, Quantitative, and Mixed Method Approaches*. London: Sage publications.

These research paradigms (presented in Table 18) illustrate different underlying assumptions. Quantitative research primarily adopts a realist/objective ontological stance and a Post positivist research paradigm. A qualitative study adopts an anti-realist/subjective approach and Constructivist research paradigm, whilst a Transformative worldview holds an underlying assumption that research needs to address oppression, domination, suppression, and alienation (Creswell and Creswell, 2018). Creswell and Creswell (2018) discuss that this type of research also assumes that the enquiry will proceed collaboratively, not further marginalising the participants they are researching. Pragmatists

do not commit to any one system of philosophy or reality. This approach tends to be used in mixed methods research as pragmatists tend to 'draw liberally from quantitative and qualitative assumptions when they engage in their study' (Creswell and Creswell, 2018, p.18).

3.2.1 Philosophical underpinnings of this thesis

Public Health and spirituality can traditionally be seen as belonging to different fields of knowledge (Oman, 2018). Public Health tends to be predominantly a scientific and nomothetic field of knowledge (knowledge gained through a scientific method, such as randomised controlled trials and experiments), whereas spirituality is usually within the subjective and ideographic field (meaningful knowledge discovered through unique, non-replicable experiences) of knowledge; therefore, they have different ways of generating truth and determining how it is generated. Within Public Health, 'knowledge' and 'truths' tend to be justified through scientific approaches such as objective measurements (such as questionnaires and surveys) (Carter and Little, 2007; Oman, 2018). However, this study explores a more subjective phenomenon (spirituality), which can be challenging to measure scientifically as, for some, spirituality is a personal, individual, and unique experience (Spencer, 2012).

In addition to this, with rapid advances in technology, it is now possible to gather both objective and subjective data within the same study relatively quickly (Voukelatou et al., 2021). Along with the increase in people identifying themselves as holding different spiritual beliefs, there are now various possible ways with which researchers can provide insight into the relationship between Public Health and spirituality (Giri, 2020; Giri, 2021). These significant advances can also present the difficulty of deciding how 'knowledge' and 'truth' is generated and gathered (Giri, 2020; Swinton and Mowat, 2016). To address some of these philosophical issues, the research paradigm used in this thesis (pragmatism) is discussed, followed by the approach to ontology and epistemology.

3.2.2 Rationale for pragmatism

Thought was given to the most appropriate theoretical stance for this thesis. The aim and objectives fundamentally guided the research, which therefore naturally adopted a pragmatic approach. The rationale for using pragmatism is that it accepts that there can be single or multiple realities open to empirical enquiry (Creswell and Plano Clark, 2011; Giri, 2020; Kaushik and Walsh, 2019; Morgan, 2014b). A pragmatic approach is a way of 'thinking or dealing with problems in practical ways, rather than using theory or abstract principles' (Creswell and Plano Clark, 2018). A pragmatic stance best fitted this thesis as it allowed flexibility and room for a wide range of new insights to develop. Research shows that a pragmatic approach enables researchers to gain a deeper understanding because it is not limited to philosophical thought (Biesta and Burbules, 2003; Giri, 2020; Tashakkori and Teddlie, 2003). Therefore, pragmatism allows for theoretical freedom, and provides a way to truth by evaluating beliefs and ideas.

Pragmatism is not without its critics. First, there is the issue of the researcher's bias, who has their own beliefs, values, and agendas when conducting the study, which may not always be explicit (Kaushik and Walsh, 2019). Some scholars argue that the human mind can only work within one type of paradigm at a time (Burrell and Morgan, 1979; Guba and Lincoln, 1990). Tashakkori and Teddlie (2003) claim that researchers within the pragmatist traditions abide by the term 'the dictatorship of the research question'. The issue with focusing on the research question is that it can become more important than anything else, whilst other factors (such as ontology and epistemology) can sometimes be overlooked (Tashakkori and Teddlie, 2003). A further issue that requires ongoing consideration is that a pragmatic researcher can read the truth into the findings or choose to focus on the data and information related to it, but potentially neglect the more difficult and complex areas of the research (Kaushik and Walsh, 2019; Morgan, 2014a). However, there is no such notion of a perfect worldview/research paradigm, and this critique is evident in all studies. It can be minimised by comparing results to previous research findings or having another researcher independently evaluate the data, especially if they hold a different worldview (Gibbs, 2002; Ritchie et al., 2013). To help mitigate this bias, this thesis compared the study's findings against some of the previous research identified in the literature review (discussed in chapter five).

3.2.3 Ontology

As highlighted in Table 18, the ontological position of a pragmatic approach is: reality/truth is 'what is useful' (Creswell and Creswell, 2018). Ontology is the study of whether something does or does not exist; people either accept that facts are real, independent of the 'human mind' (realist/objective), or

they assume that reality is subjective (anti-realist/subjective). Pragmatists believe that the process of acquiring reality is a continuum rather than two opposing and mutually exclusive poles of either objectivity or subjectivity (Goles and Hirschheim, 2000; Kaushik and Walsh, 2019; Pratt, 2016). Pragmatism is situated in the centre of the paradigm continuum in terms of mode of enquiry (Goles and Hirschheim, 2000; Kaushik and Walsh, 2019; James, 2000; Pratt, 2016).

Pansiri (2005) proposes that pragmatists doubt that reality can ever be determined once and for all. Howe (1988) asserts that pragmatists view reality as a normative concept, maintains that reality is what works, and argues that knowledge claims cannot be totally abstracted from contingent beliefs, habits, and experiences. For pragmatists, reality/truth is what helps us get into satisfactory relations with other parts of our experiences (James, 2000; Kaushik and Walsh, 2019). For this thesis, 'what is useful/the truth' was answering the aim and objectives of this thesis. At different times, objective facts were examined, for example, 'how many times participants engaged in spiritual activities'. At other times, more subjective views were investigated, such as 'the participants' definition of spirituality'. Both objective and subjective ontological approaches to reality were drawn upon to gather a range of insights.

However, 'there is a need to remember that pragmatism does not simply mean that if it works, then it's true' (Boisvert, 1998, p.31). Kaushik and Walsh (2019) point out that pragmatist researchers do not simply push aside philosophical arguments, particularly metaphysical ones, to get their research done. After careful consideration of the effort and involvement, they have concluded that the broader philosophical arguments can never be solved. This is because meaning is difficult to separate from human experience and needs, and depends on context (Dillon et al., 2000; Kaushik and Walsh, 2019). Tashakkori and Teddlie (2008) suggest that pragmatist researchers' choice of one version of reality over another is governed by how well that choice results in anticipated or desired outcomes. Goles and Hirschheim (2000, p.261) elaborate on this with the following example:

'For a more positivistic researcher, an object with flat surface and four legs would always be a table. For a constructivist, based on her/his perspective, the same object would be a table if s/he was eating off it, a bench if s/he was sitting on it, and a platform if s/he was standing on it. However, a pragmatist would define the object based on its utility, for instance, the object would be a table if s/he intends to eat off it, a bench if s/he intends to sit on it, and a platform if s/he intends to stand on it. In this example, it is important to notice that the pragmatist would not define the object based on what it is or what it is being used for, but rather based on how it would help the pragmatist achieve her/his purpose'.

The benefit of this approach to ontology is that it enables interpretations so reality and the truth to be continually developed (Kaushik and Walsh, 2019; Pratt, 2016). It allows room for flexibility, as pragmatists believe that they are free to believe anything they want, although some beliefs are more likely than others to meet their goals and needs (Morgan, 2014b; Pratt, 2016). A critique of this approach is that pragmatists consistently conduct research with their own value systems, therefore creating bias within the data, as they are finding evidence to support their assumptions (Brierley, 2017). Brierley (2017, p.19) states that with this approach 'values will have a role in conducting research, pragmatists are not overly concerned about this'. Although this is a limitation of this thesis, the ontological stance is acknowledged, and reference has been made to my preconceived ideas and values.

My personal view of ontology

I recognise that my own reality and experience has shaped my ontology, how this thesis (informs knowledge) is presented, and how the data is analysed. I am not committed to any single view of reality. In my view, reality is actively created as individuals act in the world, and it is thus ever-changing, based on human experience, and oriented towards solving practical problems (Pihlström, 2008). It is not based on the dualism between reality, being independent of the mind, and within the mind (Pihlström, 2008). Reality is constantly being renegotiated, debated, interpreted, and considering its usefulness in new unpredictable situations (Kaushik and Walsh, 2019; Patel, 2015). Personally, I tend to be oriented towards solving practical problems; this does include my approach to exploring how spirituality is perceived to influence people's health. However, as noted, a limitation of this approach is that at times different truths might be gathered and a discussion had as to which truth is most truthful/useful. To deal with this issue, I try to focus on addressing the aim and objectives of this thesis.

When it comes to examining the ontology of spiritual concepts, for example, it seems to me that notions like 'the sacred', 'the divine', 'the transcendent' or 'consciousness' can be seen as metaphysical constructions (what is in the mind), rather than rhetorical realities. These constructs are not 'set in stone'. With the same ethos as Gole and Hirschheim`s example, this thesis reports the participants' deployment of these concepts; however, it does not assume they are 'real' or 'not real'. This thesis creates insight into the participants' 'perception' of spirituality and how they perceive spirituality to affect their health. To further support this, I draw on Biesta`s (2010) research that reminds us not to merely understand pragmatism as a philosophical position, but rather as a set of philosophical tools of value for addressing problems. For pragmatists, an enquiry in both social life and Public Health research is effective only if it achieves its purposes (Hothersall, 2019).

3.2.4 Epistemology

Epistemology refers to the 'assumptions about how we know the world, how we gain knowledge, the relationship between the knower and the known' (Kaushik and Walsh, 2019, p.245). From a pragmatist point of view of epistemology, the best method is one that solves problems, and knowledge is always based on experience (Creswell and Creswell, 2018; Kaushik and Walsh, 2019). This thesis explores people`s beliefs through a practical application of Swinton and Mowat's (2016) 'Notion of Knowledge.' Swinton and Mowat (2016) claim that there are two forms of knowledge:

Nomothetic: knowledge gained by the scientific method, such as randomised controlled trials and experiments.

Ideographic: meaningful knowledge discovered through unique, non-replicable experiences.

This study is concerned with both forms of knowledge. The field of Public Health tends to apply and value a nomothetic approach to knowledge. Yet, the literature identified spirituality as more 'ideographic', as it can be viewed as an 'individual phenomenon' (Clarke, 2009; Hofstede, 2001; Narayanasamy, 2001). By only applying a nomothetic approach, valuable knowledge might be missed that cannot be measured through scientific measurements. In contrast, ideographic knowledge presumes that meaningful knowledge can be discovered in unique non-replicable experiences (Swinton and Mowat, 2016). Swinton and Mowat (2016, p.41) present ideographic knowledge in the following way:

'It is not possible to step in the same river twice; that the very act of stepping in the river shifts the riverbed and displaces the water in ways that mean, it will never be the same again. Ideographic knowledge assumes that no two people experience the same event in the same way; indeed, no individual will experience the same event in the same way twice.'

With this ideographic form of knowledge, no two people will experience the same event in the same way. A critique of this is that it could be seen as a huge assumption. However, similarities might occur, such as feelings of transcendence, happiness, and enjoyment (Swinton and Mowat, 2016). This study sought both forms of knowledge, not only as a scientific method to help apply this in Public Health and to see this study as a reliable source, but also to capture the ideographic knowledge and see if there are shared experiences among the participants. Nomothetic knowledge is needed to improve the reliability of this study (discussed in section 3.10.1.1), as there are those in the field of Public Health who still view scientific knowledge as more rigorous than ideographic/qualitative knowledge (Moffatt

et al., 2006). It was hoped that, by applying Swinton and Mowat's (2016) approach to knowledge, these 'truths' would provide insights into some of the ways spirituality may or may not affect health.

This approach to epistemology is not without its critics. Greens (2017) argues that Swinton and Mowat do not consider the overlap between these two forms of knowledge. Swinton and Mowat's (2016) approach to knowledge is also grounded in Christian theology, whereas this thesis explores those who identify as SBNR. Thus, this approach might be seen as counterintuitive. Bush (2016) claims that Swinton and Mowat's (2016) notion of knowledge can be seen as too simplistic and reductionist, whereas knowledge can be considered far richer than this. Their research around knowledge originates from theology and nursing, but this thesis has adopted it to utilise it from a Public Health perspective. Swinton and Mowat's (2016) approach to knowledge was considered most suitable for this study, coupled with their extensive research on spirituality. Applying both nomothetic and idiographic approaches has permitted a wide range of truths to be gathered, which hopefully satisfied not only those from the field of Public Health, but also allowed for further insights into 'knowledge' and 'truth'.

My personal view of epistemology

The epistemological stance I have embraced in this thesis tends to be the approach I also utilise in my everyday life. From a pragmatic point of view, I can draw on different notions of knowing depending on the question being asked. This also links back to the ontology of using what works best, and adopting this approach to the enquiry enabled new insights to develop while recognising knowledge as a continuum. I appreciate that knowledge is based on my experience and understanding of the world. Using two forms of knowledge (Nomothetic and Ideographic) was appropriate and a stance I took professionally and personally, because from my point of view, it was flexible and not absolute, which is appropriate in this ever-changing world.

3.2.5 Summary

To summarise, this thesis has adopted a pragmatic approach. The approach applied in this thesis allowed a broad scope for questioning, which potentially enhanced the overall findings. A flexible guiding paradigm acted as a basis for supporting work that combines various methods, redirecting people's attention to methodological rather than metaphysical concerns (Culver, 2012). At the same time, it also allowed the research objectives to guide the way. This was particularly appropriate as this thesis was interested in exploring how spirituality may influence people's health. Pragmatism allowed me to utilise scientific methods to apply to the field of Public Health and provided the opportunity to interpret the data both objectively and subjectively. This research can generate more in-depth

understanding and insight into this topic by potentially revealing new information that has not been exposed before, which would benefit and enrich the field of Public Health.

3.3 Introduction to quantitative, qualitative and mixed methods research

Before conducting a study, a researcher needs to consider the best way to conduct their research (Creswell and Plano Clark, 2018). In Public Health, quantitative and qualitative methods have traditionally been the main approaches to collecting data. Yet, over the last twenty years, mixed methods approaches have been developed (Oman, 2018). Quantitative research is anything that involves classification or measurement, which is predominantly analysed using statistics (Moule and Goodman, 2009; Storm, 2010; Yilmaz, 2013). Qualitative research identifies and explains meanings and beliefs, influencing what people think and feel about their health and health-related issues (Bowling, 2014). Mixed methods research is defined as research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both quantitative and qualitative approaches and methods in a single study (Creswell, 1999; Creswell and Pano Clark, 2018; Tashkkori and Creswell, 2007). The following section discusses different approaches to collecting data, including why some methods were considered over others, and a rationale for a mixed methods approach.

3.3.1 Quantitative research

Quantitative research can quantify the problem by generating numerical data or data that can be transformed into usable statistics (Kothari, 2004; Sauro and Lewis, 2016). One of the primary purposes of quantitative research is to discover how many and what kinds of people in the general population have a specific characteristic found in the sample (Brannen, 2017). One of the advantages of quantitative research is that larger sample sizes often make the conclusions from the study more applicable to a broader population (Bryman, 2016; Choy, 2014; McClean et al., 2019). Choy (2014) recommends that statistical data is often considered more reliable than non-statistical data. Quantitative research is exceptionally efficient at examining the structural features of social life (Bryman, 2016). This type of data is regarded highly in Public Health, as the more respondents agree, the more likely it is to be considered valid and reliable (McClean et al., 2019).

However, there are also limitations to quantitative research. For example, Popper (2004) argues it does not fully understand some forms of information, such as changes in emotions, behaviour, and feelings. Cornah (2006) advises that quantitative research tends to try and isolate the impact of one activity (for example, church attendance) upon another variable (for example, level of depression), which may not always capture the rich and complex interactions of other factors on any relationship

found. Another limitation of quantitative research is that it can require a large sample to apply the findings to a general population (Popper, 2004).

3.3.2 Qualitative research

Qualitative research records and analyses feelings, behaviours, and attitudes; thus, it is considered to cover the issue in-depth and in detail (Cassell and Symon, 2004; Creswell and Poth, 2016). Qualitative research can help researchers access the thoughts and feelings of research participants, which can enable the development of an understanding of the meaning that people ascribe to their experiences (Sutton and Austin, 2015). This approach can help to produce in-depth analysis, establish specific themes, identify patterns, and enrich the data (Creswell and Poth, 2016). Storm (2010) claims that a qualitative approach can give a deeper understanding of why the participants feel the way they do and help gather data on a sensitive subject. Nonetheless, qualitative research is not without its critics either. Berg and Lune (2004) argue that, unlike quantitative research, it can lack objectivity, as it may be affected by the researcher's views. This approach to data collection can be time-consuming compared to other forms of data collection, as usually the findings cannot be generalised to the study population or community. This can make it more challenging to analyse, as the data does not fit neatly in standard categories (Creswell and Creswell, 2018).

3.3.3 Mixed methods research

A mixed methods approach can help to explain findings or causal processes (Creswell, 1999; Creswell and Pano Clark, 2018; Foodrisc, 2021), and it helps to develop better, more context-specific instruments (Creswell, 1999; Creswell and Pano Clark, 2018; Foodrisc, 2021). Some researchers refer to 'mixed' methods as two sets of either quantitative or qualitative data; for example, conducting both interviews and a case study in a single piece of research.

A mixed methods approach provides a more complete and comprehensive understanding of the research problem than either quantitative or qualitative approaches could do on their own (Creswell and Creswell, 2018; Doyle, Brady, and Byrne, 2009; Guetterman, Fetters and Creswell, 2015; Wisdom, Cavaleri and Onwuegbuzie, 2012). For example, quantitative research can be weak in understanding the context or setting in which people behave, for which arguably qualitative research can compensate (Foodrisc, 2021). However, qualitative research is seen as deficient because of the potential for biased interpretations made by the researcher and the difficulty in generalising findings to a large group. In contrast, quantitative research is less likely to have these weaknesses (Foodrisc, 2021). Therefore, by using both types of research, the strengths of each approach can help make up

for the inadequacies of the other (Bryman, 2016; Creswell and Plano Clark, 2018; Foodrisc, 2021; Moffatt et al., 2006).

Of course, the use of a mixed methods approach also has its critics; for example, it can be very complex as a form of research (Creswell and Creswell, 2018). It takes more time and resources to plan and implement, and it may be challenging to incorporate one method by drawing on the findings of another (Creswell, 2014; Creswell and Plano Clark, 2018). It may be unclear how to resolve discrepancies that can arise in interpreting the findings (Creswell, 2014; Creswell and Plano Clark, 2018). For example, if data sets contradict each other, the question arises of how this should be dealt with and whether one data set could be more valid than the other. The researcher conducting the study also needs to be skilled in both qualitative and quantitative research (Creswell and Creswell, 2018).

3.3.4 Rationale for mixed methods approach

As highlighted in the literature review, most of the empirical studies that have been conducted so far have been predominantly quantitative studies, and few were conducted in the UK. Therefore, it was considered that a mixed methods approach would be the best way to address the aim and objectives of this thesis. A mixed methods approach was deemed to add value and give in-depth, broader, fuller, and more elaborate answers to the research questions; this can increase the reliability of the results (Creswell and Plano Clark, 2018). Using a mixed method approach not only enhances the robustness of the study, but it may also lead to different conclusions from those that would have been drawn by relying on one method alone (Berry, 2005; Creswell and Creswell, 2018; Moffatt et al., 2006). It demonstrates the value of collecting both types of data within a single study (Berry, 2005; Creswell and Creswell, 2018; Moffatt et al., 2006). There is also literature to show that a more widespread use of mixed methods in trials of complex interventions is likely to enhance the overall quality of the evidence base (Berry, 2005; Creswell and Plano Clark, 2018; Klassen et al., 2012; Moffatt et al., 2006).

In Public Health research, quantitative research remains the dominant paradigm (McClean et al., 2019). However, evidence-based healthcare is shifting towards incorporating both qualitative and quantitative research (Oman, 2018). Moffatt et al. (2006) argue that, at the very least, the inclusion of both qualitative and quantitative elements within a study is essential and ultimately more cost-effective, increasing the likelihood of arriving at a more thoroughly researched and better understood set of results. The literature review findings led to the rationale for adopting a mixed methods approach to explore some of the gaps that could only be addressed with qualitative and quantitative research and push for more inclusive research that incorporates both approaches.

As identified, the mixed methods approach is not without its critics (discussed in section 3.3.3). However, this thesis has attempted to address these criticisms by spending sufficient time conducting the data collection and analysis process. As the researcher in this thesis, I have some experience conducting and analysing qualitative and quantitative data; thus, I felt confident working with both forms of data. Despite the criticism, this mixed methods approach was deemed most likely to lead to an array of new insights.

Consequently, the benefits of using a mixed methods approach outweighed the limitations and supported the rationale for this approach. The quantitative data was used to base the findings for this research, and the qualitative data further expanded on these findings. It was thought that using a combination of both quantitative and qualitative data was the best way to address the objectives of this study to answer the overall aim of this thesis.

3.3.5 Rejection of other methods

Consideration was given to conducting either a purely qualitative study (with interviews), or a purely quantitative study from people identified as SBNR from the UK. As highlighted in the literature review, the benefits of these separate approaches are that quantitative analyses can enable the data to be measurable, and qualitative analyses can ensure the data is ready to be operationalised and provide deeper insight. Therefore, using both approaches to explore the potential reported relationship between spirituality and health might reveal new insights. Creswell and Creswell (2018) note that conducting a mixed methods study would reveal far greater insight than a singular method alone. Finally, a mixed methods approach can provide a comprehensive understanding of the selected subject (Creswell and Creswell, 2018; Curry and Nunez-Smith, 2014; Saks and Allsop, 2012).

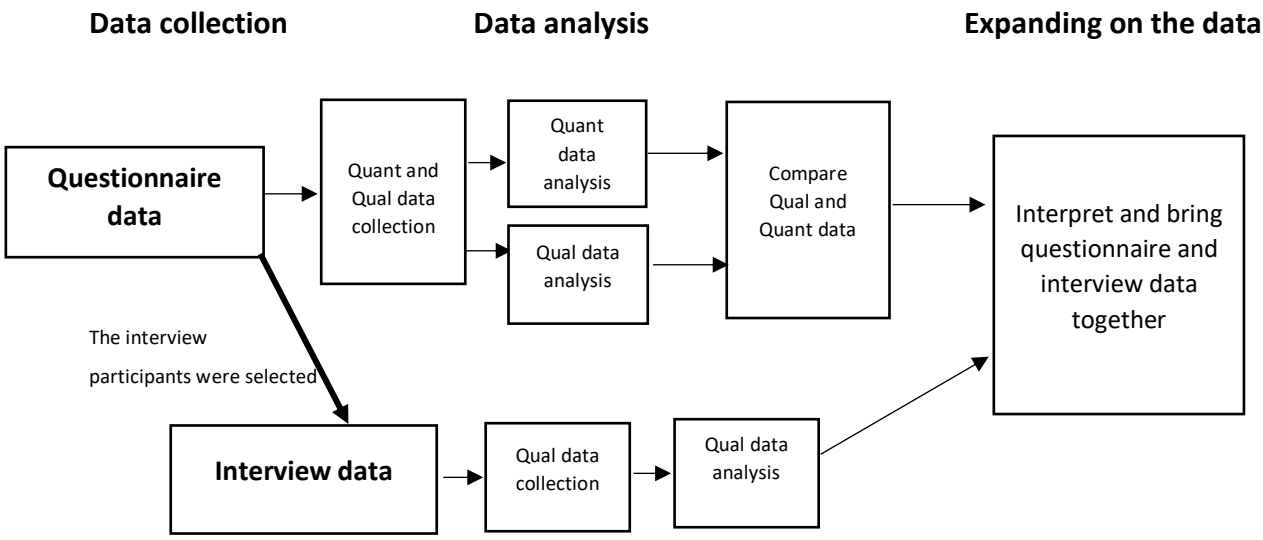
3.4 Study design: Convergent Triangulation

There are many ways to design and conduct a single study based on a mixed method approach. Authors refer to these designs in different ways, using varied terminology. Despite this, the current research has utilised Creswell and Plano Clark`s (2018) approach towards mixed methods research. Creswell and Plano Clark (2018) identify three core designs: first, the 'convergent design' which occurs when the researcher intends to gather the results of the quantitative and qualitative data analysis with the aim to combine them (Creswell and Plano Clark, 2018, p.65); Second, the 'explanatory sequential design', which occurs in two distinctive phases within a single study, for example, once the quantitative phase is complete, then the qualitative phase follows (Creswell and Plano Clark, 2018, p.65); Third, the 'exploratory sequential design', which also uses sequential timing, but typically

prioritises the collection and analysis of qualitative data first followed by the quantitative phase (Creswell and Plano Clark, 2018, p.65).

This study has utilised a 'convergent design' (demonstrated in Figure 3). This is when two data collection methods are used to obtain quantitative and qualitative data within a single study (Creswell, 2013; Creswell and Plano Clark, 2018). The current study will produce three data sets. These comprise a quantitative questionnaire, a qualitative questionnaire, and a qualitative interview data set.

Figure 3: Mixed methods design of this study



Key

Qual= Qualitative data

Quant= Quantitative data

In this thesis, both the questionnaire and interview data are used to enable insight into this subject. Using both data sets together can be referred to as 'Triangulation'. This means applying more than one method to collect data on the subject (Bryman, 2016). There are different types of triangulation. Denzin (1978) outlined the following four types:

1. Data Triangulation: The use of various sources in a study method, for example, questionnaires and interviews.

2. Investigator Triangulation: The use of several different researchers.

3. Theory Triangulation: The use of multiple perspectives and theories to interpret the results of a study.

4. Methodological Triangulation: The use of multiple methods to study a research problem, for example quantitative and qualitative data.

Data and methodological triangulation were both employed in this thesis. Data triangulation was adopted because the study used two sources to collect data: questionnaires and interviews. Methodological triangulation was also applied, as both quantitative and qualitative data were collected. This type of triangulation can elucidate complementary aspects of the same phenomenon; it is often the points where these data diverge that are of great interest to the qualitative researcher and which provide the most insight (Denzin, 1978; Patton, 2001).

The main rationale for, and benefits of, using triangulation is that it allows: greater validity in a study seeking corroboration between quantitative and qualitative data (Doyle, Brady and Bryne, 2009); completeness, as using a combination of research approaches, provides a more complete and more comprehensive picture of the studied phenomenon (Casey and Murphy, 2009); and it helps to minimise the weaknesses of using only one method (Bryman, 2006; Creswell, 2013), as well as creating a clearer picture of the phenomenon being studied (Bryman, 2006). This approach can increase knowledge and strengthen the researcher's standpoint from various aspects (Bryman, 2016). Even though triangulation is widely used in mixed methods literature, it can be problematic within both qualitative research and mixed methods research because it may lead some researchers to pick out the points of similarity within the findings whilst ignoring differences (Erzberger and Kelle, 2003; Fielding and Fielding, 1986). This thesis addressed this potential issue by being mindful of it and ensuring that the differences were discussed (for example, in the results chapter section 4.6.3). I was cognisant of this concern when conducting the data analysis so as not to miss vital information and make sure the focus was on addressing the objectives of this study.

To summarise, using a 'convergent design' including 'data triangulation' and 'methodological triangulation' enabled the creation of a more holistic picture. The questionnaires and interviews were the best way to collect this study`s data, as they allowed a wide range of information to be gathered in a rigorous manner (discussed in more detail in section 3.10.2.1). This approach was appropriate as the topic to be explored was complex, and interviews would allow for a deeper understanding of the answers. For this thesis, using more than one data collection approach to investigate a research question enhances confidence and ensures the findings are more reliable, if carried out correctly (Denscombe, 2010; Fielding, 2012; Yeasmin and Rahman, 2012). This meant triangulation was essential to collate the findings.

3.5 Data collection methods

There are many methods for collecting qualitative and quantitative data, such as questionnaires, interviews, focus groups, and observations. A questionnaire was deemed the most appropriate approach for one part of this study, given that it is practical, inexpensive, time-efficient, and an easy way to gather many peoples' opinions. From a Public Health perspective, questionnaires and surveys are preferred methods of gathering reliable evidence (McClean et al., 2019; Oliver and de Vocht, 2017; Yu et al., 2009). These approaches can be seen as more quantifiable and easier to recreate, with less bias and enabling a large sample to be collected (McClean et al., 2019). Furthermore, observations or case studies did not seem appropriate in relation to the aim and objectives, because this study intended to recruit a wide range of people to ask them about a complex concept, in this case their spiritual beliefs (Bowling, 2014; Holloway and Wheeler, 2013; LoBiondo-Wood and Haber, 2014). Observations and case studies can make it more challenging to provide generalisations and replicate the study, and researchers' own subjective feelings may influence the case study (researcher bias) (Beiske, 2007; Hodkindon and Hodkindon, 2001).

Each data set had a different role; questionnaires were designed to attract a wide range of participants. Questionnaires conducted online were more likely to be trustworthy as the researchers are not present; this ensures they cannot influence the participant's potential bias (Saris and Gallhofer, 2014). On the other hand, interviews helped explore individual participants' views, experiences, beliefs, and motivations in more detail (Morris, 2015; Seidman, 2013). The interviews were also used for triangulation to ensure that responses were rich, robust, comprehensive, and well-developed (Discussed in more depth in section 3.5.2) (Denzin 1978; Patton, 2001). They also allowed a deeper understanding of experiences, opinions, attitudes, and values, which was essential when studying a subjective topic such as spirituality.

No data set was more powerful than the other. This research was conducted to allow the data sets to complement each other. The questionnaire data set is presented first in this thesis as it was completed first, and the interviews were subsequently used to expand on the questionnaire's findings.

3.5.1 Data collection method: questionnaire

An online questionnaire was used as a data collection method for this study, because questionnaires are considered easy to standardise. Every respondent is asked the same question in the same manner (Converse and Presser, 1986; Hai-Jew, 2019). The benefit of questionnaires is that they can be anonymous and completed in privacy (Blair, Czaja and Blair, 2013; Hai-Jew, 2019; Hanson et al., 2005). Questionnaires also allow participants' views to be gathered quickly. Additionally, another reason for

using a questionnaire is that there is an increased chance that the people who answer the questions would be more honest, as they are not intimidated by the presence of a researcher (Blair, Czaja and Blair, 2013; Jasper, 2003). Questionnaires, then, were a valuable tool to meet the aim and objectives of this study, as they are a reliable and credible way to collect data and ask people questions directly related to the research topic (Bernard and Bernard, 2012; Fowler, 2013).

Nevertheless, there is some criticism of the use of questionnaires; for example, they might be inadequate to understand some forms of information (such as changes in some people`s emotions) (Ackroyd and Hughes, 1981; Hesse-Biber, 2010). The questionnaire may also not reach those not present on social media. Additionally, Creswell and Creswell (2018) point out that there is no way to tell how 'truthful' an answer is or how much 'thought' a respondent has put into the answers. Popper (2004) suggests people may read a different meaning into each question and therefore reply based on their interpretation of the question; what is 'good' to one person may be 'poor' to someone else. Then there is the issue of the 'level' of researcher imposition, meaning that, when developing the questionnaire, the researcher is making their own decisions and assumptions as to what is essential (Bowling, 2014; Creswell and Plano Clark, 2007). Ellison (2007) proposes another concern with this approach: the only people whose behaviour and opinions are represented in the study are the people who decided to join and start using the specific site or service in question. Despite these limitations, to help ensure the answers were more truthful, clear, and easy to understand, they were not leading questions. To illustrate this, a leading question would be: 'Did you notice spirituality had a positive effect on your health?' To rephrase it as a non-leading question would be: 'Does spirituality affect your health?' These questions were tested by asking for feedback from other knowledgeable people on the questionnaire design before this study was conducted. The researcher's contact details were provided at the beginning of the questionnaire if further clarity was needed. However, no participant made use of this option.

This thesis utilised an online questionnaire as one of its data collection methods. There are other ways to distribute a questionnaire, such as by post, telephone, or in-person, but online seemed to be the best way to target the intended respondents for this research as it could reach the SBNR population more easily. As discovered in the second literature review, some people who identified as SBNR used online social media to connect with other people who identified as SBNR (Baker, Stroope and Walker, 2018; Cimino and Smith, 2010); thus, this seemed like an appropriate way to target the intended population. Collecting data 'online' through social networking sites is a relatively new way of data collection (Church and Waclawski, 2017; Reips, 2012). It has many advantages, as it is a method to connect to a wide range of people from different backgrounds, who may have different experiences

and who might not always be well-represented in research (Hai-Jew, 2019; Hargittai, 2015). It is a relatively easy way to ask for people's thoughts and opinions and target a specific audience (Blair, Czaja and Blair, 2013; Reips, 2012). A critique of this approach (more limitations are discussed in 3.7) is that it only provides a snapshot of people's thoughts and opinions at one particular time (Denzin, 2017; Nardi, 2018). The questionnaire was shared on several online social networking sites to increase participation reach (more in-depth details of this process are discussed in section 3.7.2).

3.5.2 Data collection method: interviews

At the end of the questionnaire, people were given a choice to leave their contact details to be contacted about participating in follow up interviews. Interviews were conducted to help expand and compare the questionnaire data findings. Alternative follow-up data collection methods could have been used, such as a focus group or a follow-up questionnaire. However, interviews were deemed the most appropriate choice to enable a more profound understanding (Barbour and Schostak, 2005; Cassell and Symon, 2004; King and Horrocks, 2010). In this thesis, interviews were a way to elicit more detailed insights into the meaning of spirituality in people's lives and a deeper understanding of the impact it may have on their health. Interviews provided the opportunity to generate rich and additional data, and their contextual and relational aspects were significant to understanding others' perceptions (Barbour and Schostak, 2005; King and King and Horrocks, 2010). They were also valuable as a follow-up method to certain respondents' questionnaires, for example, to further investigate their responses (LoBiondo-Wood and Haber, 2014; Morris, 2015; Seidman, 2013).

The interview data assisted in answering the research questions as it encouraged people to expand on their responses and discuss new topic areas which the researcher may not initially have considered (Cassell and Symon, 2004; King and Horrocks, 2010; Opdenakker, 2006). Berg and Lune (2004), Doody and Noonan (2013) note that this is the most practical way to gather this data, as participants were simply being asked for their opinions. There are many advantages to using interviews as a method of collecting data, as not only can all the questions be asked in the same way, but they can help to ensure questions are completely understood (Barbour and Schostak, 2005; Bryman, 2016; Jacob and Furgerson, 2012; Mayan, 2016). Interviews were deemed the most appropriate method, in conjunction with other data collection methods in this research, because these benefits potentially allowed a deeper and more comprehensive understanding of the responses.

However, there are limitations to using interviews as a data collection method; they can be time-consuming (Bowling, 2014; King and Horrocks, 2010); the interviewer could ask leading questions that may cause bias; and the participants are required to invest their own time (Bowling, 2014; King and

Horrocks, 2010). This study minimises these criticisms by adhering to a strict timeframe, recognising the research bias, and testing the interview guide beforehand (discussed in section 3.8.2) (Carr and Worth, 2001; Opdenakker, 2006). This does not eliminate the researcher's bias entirely, but it does recognise the issue and helps to minimise its impact. In addition, to reduce the burden on participants, they were not required to give excessive amounts of their time if they chose not to. They also freely chose to participate by leaving their contact information.

3.6 Design of the questionnaire

The questionnaire consisted of semi-structured and structured questions to explore people's perceptions. Semi-structured questions can allow people to express their opinions (Longhurst, 2003). These questions can provide in-depth answers and a general overview of what the participants think (Creswell and Clark, 2007; Taylor, Bogdan and DeVault, 2015). It has been recognised that semi-structured questions do have their limitations, such as the fact that participants` responses are more open to different interpretations (Holloway and Wheeler, 2013). Jasper (2003) claims that semi-structured questions can be more time consuming to complete than structured questions, and participants must have requisite literacy skills. This study acknowledges these criticisms, but it is considered that the use of semi-structured questions would be a practical way to explore people's perceptions for which there is no easy 'yes' or 'no' answer. Structured questions were used because they are the most appropriate way to collect similar responses and analyse data on a large scale (Valentine, Nembhard and Edmondson, 2012). Structured questions have limitations in that they are not the best method for examining complex issues and opinions (Bowling, 2014; Hai-Jew, 2019). However, structured questions were useful in this study to generate quantifiable data and gather a broad range of 'shared truths', as many participants gave the same answers. Patton (2002) notes they are also valuable as structured questions allow people to respond to the same question, making it easier to find and compare responses during analysis. Thus, both structured and semi-structured questions were used because this thesis wanted to provide the opportunity to generate rich data that can be explored in many ways.

The questions flow from the more general to the more specific, with the order of the questions as 1) health; 2) definition of spirituality; 3) spiritual practices; 4) spirituality in relation to health; 5) participants` demographics. The order of the questions and how they are asked can affect the overall results (Saris and Gallhofer, 2014). The order was determined this way because a decision was taken to collect the most critical data first, as some researchers suggest that participants might start to lose interest as the study progresses (Patten and Newhart, 2017). In this study, the wording of the questions was kept as direct and straightforward as possible, and most of the questions were less than

ten words, to maximise readability. This meant that people were likely to complete the questionnaire, and the data would be more reliable if participants understood what they were being asked (Shaughnessy, Zechmeister and Jeanne, 2011).

There is also the issue of the participants not taking the time to read the more extended questions in the questionnaire, which would not produce accurate results (Mellenbergh, 2008). Patten (2016) proposes one way to minimise this issue was by keeping the questionnaire as short as possible, varying the questions and making them easy to understand, so that participants would be discouraged from consistently ticking downwards on the questionnaire. It was also recognised that there is a level of researcher imposition; this means that, when developing the questionnaire, researchers make their own decisions and assumptions as to what is and is not essential, thus potentially missing something that is of high relevance (Patten, 2016; Popper, 2004).

3.6.1 Formulation of the questionnaire questions

The questionnaire questions were designed to meet the aim and objectives of this research. This section is set in chronological order in line with the five objectives and how the questions were formulated to answer each objective. The full questionnaire can be found in Appendix 8.

The health of the participants

To answer objective one: To ascertain the participants` self-perception as to whether they considered themselves healthy or not.

Two questions were formulated to address objective one. First, the participants were asked if they considered themselves to be healthy. A structured question was used: 'Do you consider yourself healthy?' The participants could then choose from the following options: yes, no, or not sure. This information was useful because the literature review identified that little research had been conducted on individuals who were reported to be 'healthy'. This was the premise and target audience for this study. Second, if the participants stated they were unhealthy, they were asked 'why'. If the participant defined themselves as unhealthy, but their evidence did not support this assessment, the answer was not changed. This question was asked because it helped provide insight into the different reasons why the participants perceived themselves to be unhealthy. If appropriate, this could be related to previous research conducted on those who identified as having some form of illness, for example depression or cancer. Those who identified as unhealthy were excluded from the rest of the data set, to focus on the intended target population (discussed in more depth in section 3.9.1). These two questions seem suitable and sufficient to address the first objective.

Definition of spirituality

To answer objective two: To explore the definition of spirituality from the participants` perspective.

Both qualitative and quantitative measures were used to explore how spirituality was defined. The literature review identified different methodological measures (such as spiritual tools, health measures, people`s thoughts and feelings) to produce additional insights (Weaver et al., 2003). In addition, there was research to show methodological issues about how the definition of spirituality differs depending on the measurements being used; for example, the use of spiritual experiences, practices, and themes (Berry, 2005; MacDonald, 2011; Oman, 2018). In total, three questions were formulated to address objective two. The participants were first asked if 'they considered themselves to be spiritual.' This was a structured question and the central premise of the research. This question was vital because those who considered themselves spiritual were the focus of this research, and those who did not might provide different answers. Those who did not identify as spiritual were excluded from the data set.

For the second question, the participants were then asked, 'how do you define spirituality?' This was an open text box question and was formulated because previous literature had established that the term `spirituality` could have various meanings to different people (Clarke, 2009; Hulett and Armer, 2016; Narayanasamy, 2001; Williams and Sternthal, 2007). Therefore, to deal with this issue, the participants were asked to define spirituality for themselves. The answers can then be thematically analysed (discussed in section 3.13.2).

The next structured question asked the participants to tick words or phrases that had any bearing on their own sense of spirituality. This question was developed from the concept analysis and themes found in the literature review of spirituality, which identified six elements of spirituality (discussed in section 2.17.1). These six elements were then formed into dimensions of spirituality to be measured: multidimensional (which was phrased as 'feeling complete as a person'); self-actualisation (which was phrased as 'feeling that you can achieve your full potential'); connection (which was phrased as 'feeling connected to someone or something outside yourself'); a sense of purpose (which was phrased as 'feeling that you can achieve your full potential'); happiness (which was phrased as 'experiencing something that makes you feel happy with your life'), and finally love (which was phrased as 'experiencing a sense of love from someone or something outside yourself'). How this question was presented is shown in Figure 4. The participants were permitted to tick as many options as they wished.

Figure 4: The structured question about spirituality

Researchers have identified several possible aspects of spirituality that we are interested in. Please tick which of these words or phrases have any bearing on your own sense of spirituality if you have one (Please tick all those that apply).

- ☐ Feeling connected to someone or something outside yourself.
- ☐ Feeling complete as a person.
- ☐ Feeling that you can achieve your full potential.
- ☐ Having a sense of purpose.
- ☐ Experiencing a sense of love from someone or something outside yourself.
- ☐ Experiencing something that makes you feel happy with your life.
- ☐ The above words and phrases are not applicable to me.
- ☐ Please add any words or phrases, not on the above list, which are important to you when you think about spirituality.

Spiritual practices

To answer objective three: To explore the participants` spiritual practices.

Five questions were formulated to explore people's spiritual practices and level of engagement for objective three. Both quantitative and qualitative questions were formulated. Led by the second literature review (discussed in section 2.14.1.3), Mercadante (2017; 2020) found that spiritual practices in which the SBNR population participated included praying or reading scriptures, occasionally attending religious services, or experimenting with non-western faiths. Subsequently, guided by Mercadante`s findings, this thesis wanted to explore if this was the same in the UK. The questions were then formed to ask: 'do you engage in spiritual activities?', 'What spiritual practices do you engage with?' Or 'how often do you engage in the spiritual activities or practices you mentioned above?' This information could then be cross-referenced with previous answers (such as if the participants identified as being spiritual, or how spiritual practice might have influenced

different health dimensions) in order to develop a better profile and cross-reference to previous literature, such as Mercadante's research.

The participants in this study were asked 'where' and 'how often' they engaged in spiritual practices. This was because previous research suggested there might be a relationship between the frequency with which people engage with spiritual activities and how they perceive it to impact their health (Maselko and Kubzansky, 2006; Oman, 2018); therefore, these questions were asked.

Participant's perceptions of how spirituality may influence health

To answer objective four: To explore the reported relationship between the participants' spiritual beliefs and their health.

To meet objective four, the research followed Scriven`s (2017) dimension of health (discussed in section 2.17.4). The questions were formulated by separating health into the following six dimensions: physical, emotional, mental, social, societal, and spiritual health. The benefit of qualitative data would add a greater understanding of how spirituality as a subject phenomenon may be reported to influence health, while the benefit of quantitative data would add numerical data that can be quantifiable to add another dimension of insight (Weaver et al., 2003).

As illustrated in Table 19, each component of health is divided into its particular 'dimension' and the elements that form that dimension. These were developed from Scriven's description of the dimension of health. For example, emotional health was defined as: 'the ability to recognise feelings and to express them appropriately, such as coping with stress, tension, depression and anxiety' (Scriven, 2017, p.8). This definition of emotional health was divided into four key elements: 'my emotional health,' 'my joy of life,' 'my mood', and 'my self-esteem' to ensure all the elements of that theme were encompassed. The same process was applied to the other dimensions of health. The definitions of the other five dimensions of health are detailed in section 2.17.4.

Table 19: Sections of each dimension of health

Physical health	Emotional health	Mental health
My overall physical health. My overall physical fitness. The amount of exercise I do. Prevention of illness. My diet. My sleep.	My emotional health. My joy of life. My mood. My self-esteem.	My communication with others. My concentration. My ability to think clearly. My stress levels.
Social health	**Societal health**	**Spiritual health**
My social health. My relationship with my family. My relationship with my partner. My ability to make friendships. My ability to maintain friendships.	My engagement in the wider community. My sense of personal safety. My sense of belonging.	My spiritual health. Feeling secure in my beliefs. My ability to engage in spiritual activities. How often I engage in spiritual activities. Feeling connected to something bigger than myself. My feeling of being at peace.

The first literature review identified that most of the studies to date predominantly focused on one aspect of health, for example mental health (Braam and Koenig, 2019; Milner et al., 2020; Smith-MacDonald et al., 2017) or physical health (Gonçalves et al., 2017; Moreira et al., 2020). A limitation of focusing on one aspect is that other possible findings on other dimensions of health could be missed. The benefit of looking at more than one area of health is that it can provide a more comprehensive understanding of the potential reported relationship between spirituality and dimensions of health (Hulett and Armer, 2016). Hence, this research tried to address this gap by asking about several dimensions of health within one study.

For all these dimensions of health, Likert scale questions were developed (examples of these questions are presented in Figure 5). Likert scales allow individuals to express how much they agree or disagree with a particular statement (Likert, 1982). These scales represent people's attitudes to a topic (Dawes, 2012; Hair, Bush and Ortinau, 2006; Malhotra and Peterson, 2006). The advantages of using a Likert scale are that it tends to be a universal method for survey collection, and therefore they are easily understood (Boone and Boone, 2012). Likert scales do not require the participant to provide a concrete 'yes' or 'no' answer, as it does not force them to take a stand on a specific topic but rather allows them to respond in a degree of agreement; this makes question-answering easier for the respondent (Jamieson, 2004). Another reason why they are beneficial is that the responses are easily quantifiable and can be mathematically analysed (Allen and Seaman, 2007). A criticism of a Likert scale

is that people might just tick down on one side if they lose interest in the survey/questionnaire (McLeod, 2019). Another critique is that they can be considered a 'lazy' way to ask questions (McLeod, 2019). They also do not allow for any in-depth individual views to be ascertained.

However, as identified in the literature reviews, much of the previous spiritual research used Likert scales (for example, Gijsberts et al., 2011; Monod et al., 2011; Selman et al., 2011). This was because it was seen as an easy way to measure/assess spirituality and spiritual health (Hungelmann et al., 1996). This approach, then, was a way to attain an understanding of people's attitudes on a particular topic.

The most common Likert scales are five or seven-point formats (Dawes, 2012; Malhotra and Peterson, 2006). Previous research on spirituality and health has also used this format (Gijsberts et al., 2011; Hungelmann et al., 1996; Monod et al., 2011). Johns (2010) and Pell (2005) advise using an odd number point scale, which means that participants can be 'neutral' or indicate 'no effect', which tends to be in the middle. Another argument is that people avoid choosing the 'extremes' options on the scale because of the negative implications involved with 'extremists,' even if an extreme choice would be the most accurate (Likert, 1982). For this thesis, a five-point Likert scale was deemed the most appropriate because research suggests five-point scales appear to be less confusing, increasing the response rate and reducing respondents' 'frustration level' (Babakus and Mangold, 1992; Devlin, Dong and Brown, 1993; Hayes, 1992; Marton-Williams, Worcester and Downham, 1986).

Figure 5: Example of one question from each of the health dimensions

Please select one answer from each of the questions below by clicking the numbers in each of the columns to show which best represents the impact that spirituality has on your health:

Spirituality is defined as that which seeks to transcend the self and find meaning and purpose. This could be achieved through connection and engagement with others, the surrounding environment or oneself.

Please give just one response to each of the following items as follows:

	It has a strong negative effect	It has a somewhat negative effect	It has no effect at all	It has a somewhat positive effect	It has a strong positive effect
My physical health	○	○	◉	○	○
My emotional health	○	○	○	○	○
My communication with others	○	○	○	○	○
My social health	○	○	○	○	○
My spiritual health	○	○	○	○	○

Figure 5 provides an overview of a question from each health dimension. The order of this section of the questionnaire was randomly generated (performed by the Qualtrics software), in terms of exactly which dimension of health was featured first. As identified in Table 19, the subthemes stayed together, for example, 'my overall physical health', 'my overall physical fitness', and 'the amount of exercise I

do', which were all part of physical health. This was to prevent the questionnaire from appearing disjointed.

Following the Likert scale questions, there was an open text box question for each dimension of health (Figure 6) in which the participants could write comments (with the instructions that said: 'Please state: How does your spirituality affect the following?'), thus enabling qualitative data to be generated to expand and support the quantitative answers.

Figure 6: Framing of health dimensions open text box question

How does your spirituality affect the following? (skip those who do not apply)

Your physical health (for example, exercise, diet, movement, lifestyle choices).

Your emotional health (for example, feeling happy, joyful, sad or stressed).

Your social health (for example, going out with friends, engaging with people in the community).

Your engagement in the wider community (for example, feeling connected and a sense of belonging).

Your spiritual health (for example, example, a way of achieving peace of mind and being at peace with oneself).

The participants' demographics

To answer objective five: To explore whether the demographic factors impact spirituality and the participants' health.

The participants were asked to supply information about their gender, age, occupation, education, ethnicity, and where they were born in the UK. As identified in the literature review, these demographic factors were also included in previous studies (Baker, Stroope and Walker, 2018;

Hayward et al., 2016; Kelly and Eddie, 2020; McClure and Wilkinson, 2020; Saunders et al., 2020; Speed and Fowler, 2016; Willard and Norenzayan, 2017) and tend to be the standard categories of the population explored in research (Hughes, Camden and Yangchen, 2016; Lau, 2017; Williamson and Johanson, 2017).

Five questions (including two follow-up questions concerning employment status and an additional question on location) were formulated to gather information about the participants' demographics. Predominantly quantitative data was asked in this section. For example, for the question 'What is your gender?' the participants had a range of choices to choose from: 'female', 'male', 'other', or 'prefer not to say'. This same question structure has been used in previous research (Kelly and Eddie, 2020; Speed and Fowler, 2016; Van der Tempel and Moodley, 2020).

Another example of a question asked in this section was 'How old are you?'. The participants had a range of age choices to choose from: '18–30, 31–40, 41–50, 51–64, 65+,'and 'prefer not to say'. This was due to the fact that, if people are asked their age within a range of, say 31–40, they are generally more inclined to give their age honestly, because it can feel less invasive (Smith, 2006). Gupta (2014) explains that some people do not like stating their age. For this reason, in the online questionnaire, a 'prefer not to say' box was added. This was incorporated into all the demographic questions, so the participants did not feel they had to provide an answer if they did not wish to do so.

Kelly and Eddie (2020) noted that there should be further exploration around ethnicity in relation to spirituality, as they found that, for white participants, there was a clear declining relationship in the importance of the role that spirituality plays in the recovery of people suffering from illness in comparison to black participants. This was further investigated by asking the participants about their ethnicity. Two questions about employment and salary were also asked. This can be compared to the literature findings, as Kelly and Eddie's (2020) research considered household income and salary. Willard and Norenzayan (2017) also found that income was not different for the non-religious and the SBNR population, and that there were no significant effects on educational attainment. Therefore, it made sense to look at these specific demographic factors as the previous literature had done.

Information about the participants' location was beneficial, as it helped identify where they were based (Eysenbach and Wyatt, 2002). This might provide insight into where the participants are in the world, but also Davidson (2001) and Raymond and Profetto-McGrath (2005) explain that asking participants questions about themselves in the questionnaire and the interviews can make people feel more valued; consequently, they are more likely to be honest and to complete the questionnaire.

With regard to the demographic data, Smith (2008) states that current evidence indicates certain prevalent trends among individuals who do and do not participate in questionnaires. Some research shows that first, women are more likely to participate in questionnaires than men (Curtin, Presser and Singer 2000; Moore and Tarnai, 2002; Singer, Van Hoewyk and Maher, 2000); second, younger people are more likely to answer questionnaires than older people (Goyder, 1986; Moore and Tarnai, 2002); third, the more educated (as in those who achieved in higher education) and more affluent (earning more than the minimum wage) were more likely to participate in questionnaires than those who are less educated and less affluent (Curtin, Presser and Singer, 2000; Goyder, Warriner and Miller, 2002; Singer, Van Hoewyk and Maher, 2000); finally, there is some research to suggest those who identify as 'white' are more likely to participate in questionnaires than other ethnic minorities (Curtin, Presser and Singer, 2000; Groves, Singer and Corning, 2000; Voight, Koepsell and Daling, 2003). All these factors have been shown to influence response rate and sway the demographic data. Other additional factors have been shown to influence response rates, including the questionnaire topic, the methods of contact, data collection, and the wording of the questionnaire title (Dillman, 2000; Dillman and Frey, 1974; Goyder, 1987; Groves, Singer and Corning, 2000; Hox and Deleeuw, 1994; Lund and Gram, 1998; Miller, 1991). All these points were considered when designing the questionnaire to attract a wide range of participants, to be inclusive while considering the intended target audience (discussed in section 3.6).

The demographic questions were asked at the end of the questionnaire in order not to deter people from completing the questionnaire. Dillman (2000) recommended placing demographics questions at the end, rather than at the more conventional beginning of the questionnaire. This is a beneficial way of encouraging people to complete the questionnaire, as the participants are answering the questions, they perceive to be interesting and socially useful first (Dillman, 2000; Green, Murphy and Snyder, 2000). Questions were structured according to the type of data being collected; for example, closed structured questions/open-ended semi-structured questions. The questions were based on fundamental concepts identified in the literature review and the research questions.

The final question of the questionnaire asked the participants to leave their contact details if they were happy to be contacted for a follow-up interview. The interview participants were recruited this way because having completed the questionnaire indicated that they were interested in the subject; consequently, they were more likely to be willing to provide more in-depth answers and further clarification of their answers if required.

3.6.2 Rejection of validated spiritual tools

As the literature review highlighted, hundreds of validated spiritual tools have been developed to help provide objective measurement and identify people that may require additional spiritual support (Monod et al., 2011). The benefits of these validated spiritual tools include providing measures that treat everyone the same and identifying patients that may require additional spiritual (and general) support (Monod et al., 2011; Selman et al., 2011). They can be used as a relatively quick way to assess aspects of people's spiritual health (Monod et al., 2011; Selman et al., 2011). However, there are limitations to the validated spiritual tools, as they were predominately designed for those experiencing ill health and could therefore be perceived as not encapsulating all the elements of spirituality and health (Monod et al., 2011; Selman et al., 2011). Lewis (2008) also notes that some of the measures found are relatively new and, as a result, have not had the opportunity to undergo psychometric scrutiny.

Upon further examination, the literature showed that many of the validated spiritual tools required further testing for reliability and were only used among specific populations or within certain healthcare settings (Monod et al., 2011; Selman et al., 2011). There are also issues around the lack of consistency within the individual tools as to the variables being measured; for example, some of the measures include measures of religious affiliation, or lack of religious affiliation, and/or participation in spiritual practices, while others did not (Gijsberts et al., 2011; Lewis, 2008; Monod et al., 2011; Selman et al., 2011). Due to these limitations, and the fact that this thesis wanted to focus specifically on spirituality in the UK on healthy populations (which, to date, no validated spiritual tools have been tested on), no validated spiritual tools were used in this thesis.

3.6.3 Questionnaire length

In total, there were nineteen core questions in the questionnaire for this study, which took approximately ten to fifteen minutes to complete. This was similar amount of time to previous questionnaires within this field (Baker, Stroope and Walker, 2018; Hayward et al., 2016; Willard and Norenzayan, 2017). There is no consensus about the optimal length of questionnaires. There is a general consensus that short, simple questionnaires usually attract higher response rates than longer, more complex ones (Ackroyd and Hughes, 1981; Bolton, 2001). This study's questionnaire was kept as short as possible to make it user-friendly and to enable data to be gathered from as many participants as possible. Andrew and Halcomb (2009) and Gerrish and Lacey (2006) highlight the importance of completing all questions. An incomplete questionnaire can potentially alter the results by making the

data more difficult to analyse, affecting the validity of the findings (discussed in more depth in section 5.7) (Andrew and Halcomb, 2009; Gerrish and Lacey, 2006).

3.6.4 Questionnaire format

In order to maximise the number of participants, it is essential to consider the questionnaire's appearance, layout, and length. It has been proposed that the wording on the front of the questionnaire should not be too complicated, as that can discourage people from participating (Pawson, 2006). The design and format for this study were created using a specific online computer programme known as 'Qualtrics'. This online computer programme is widely used; the text and design are clear; moreover, it is easy to gather data and has automatic data input and handling (Buchanan and Hvizdak, 2009). Figure 7 demonstrates the Qualtrics design. Consequently, the design of this study was kept simple and clear to encourage as much participation as possible.

Figure 7: An example of a Qualtrics questionnaire design

Qualtrics (2017) *Questionnaire Design.* Available at: http://edx.readthedocs.io/projects/open-edx-building-and-running-a-course/en/latest/exercisestools/qualtrics.html (Accessed: 8 March 2017).

The Qualtrics system allows the data to be organised and the results grouped together, making it easy to analyse as it helps to organise the data quickly (Wright, 2005). This online survey tool was used to format the online questionnaire. To make it more accessible, participants could change the colour of the font, design, and make the text larger or smaller. Other software can be added to Qualtrics, including 'Claroreader Plus,' which can read the text on the computer screen aloud and change the text's language to suit the participant. These features allow greater accessibility for those with literacy difficulties or visual impairment. The participants could enhance accessibility by following the information on the front page of the questionnaire. It was impossible to tell how many people used 'Claro reader Plus' due to how the web link was set up, but it was offered as an 'extra' to enable as many people as possible to participate. The participants could go back and change their answers in previous sections if they wished to do so.

3.6.5 Testing the questionnaire design

The questionnaire design was tested by a small sample of people prior to being used. The advantage of doing this is that it can provide feedback on the data collection tools, improving the study's overall credibility (Arain et al., 2010; Cadete, 2017; Van Teijlingen and Hundley, 2002). Before disseminating the questionnaire, six people were asked to give feedback on the questions in the questionnaire. Two academics and four lay people were asked to fill in the questionnaire and provide verbal feedback to ensure that the meaning of the questions used in the questionnaire was clear and as straightforward as possible. These people were specifically chosen because they had expertise within the area. The two academics knew about creating questionnaires and conducting mixed methods research. The four laypeople had an experience with SBNR but also were able to provide feedback on the design of the questionnaire.

These six participants were asked what they thought about the questionnaire and how it could be improved. Their responses were considered, and the questionnaire was edited accordingly. Although a pilot study was not conducted, feedback from the questionnaire was applied by applying Foodrisc (2013), which provides 'guidance on testing the survey instruments'. This was drawn upon to enable feedback on this study`s questionnaire design. Foodrisc (2013) provides a list of questions to ask the sample for feedback (presented in Table 20). These questions were asked to all six of these participants.

Table 20: Feedback on the questionnaire design

Questions for questionnaire feedback	**Participant feedback**					
	Academic (female)	**Academic (male)**	**Lay person (female)**	**Lay person (female)**	**Lay person (female)**	**Lay person (male)**
Are instructions for completing the survey clearly written?	Yes	Yes	Yes	Yes	Yes	Yes
Are questions easy to understand?	Yes	Yes	Yes	Yes	Yes	Yes
Do respondents know how to indicate responses (e.g., circle of mark the response; use a special pencil; use the space bar)?	Yes	Yes	Yes	Yes	Yes	Yes
Are the response choices mutually exclusive?	Yes	Yes	Yes	Yes	Yes	Yes
If a computer-assisted/web survey, can respondents correctly use the commands?	Yes	Yes	Yes	Yes	Yes	Yes
If a computer-assisted/web survey, do respondents know how to change (or "correct") their answers?	Yes	Yes	Yes	Yes	Yes	Yes
Is privacy respected and protected?	Yes	Yes	Yes	Yes	Yes	Yes
Do respondents have any suggestions regarding the addition or deletion of questions, the clarification of instructions, or formatting improvements?	Change wording of the question: How does spirituality influence your societal health? Unclear what the question meant.	Remove question: Is your gender identity the same as the gender you were assigned at birth. It did not seem relevant to the research.			Remove question: Is your gender identity the same as the gender you were assigned at birth. It did not seem relevant to the research.	Vary the size of the text to make it easier to read.

Table 20 is adapted from Foodisc (2013) *Questions to ask when testing survey instruments.*

Table 20 presents the feedback given by the people who tested the questionnaire design. The two academics and the four lay people's responses did not significantly differ. Overall, they were happy that the questionnaire was straightforward, and the questions were easy to understand. Four of the participants suggested three changes (illustrated in Table 20). Therefore, after listening to the feedback, the recommended changes were made to the questionnaire.

Three changes were made to the questionnaire based on this feedback: 1) Rephrasing one of the questions into more straightforward language: 'How does spirituality influence your societal health?' was changed to: 'Does spirituality influence your engagement in the wider community?'; 2) The question on 'Is your gender identity the same as the gender you were assigned at birth?' was removed due it to not being considered appropriate; 3) The font of all questions was made larger throughout the questionnaire. The font went from a size 10 to 12. The text of the cover sheet/front page was increased in size to improve readability. For question 10, the wording was made bold to make it stand out to the reader as that was what was recommended by one of the lay participants. These six participants approved of the new wording of these questions in reference to points one and two. Testing the questionnaire data collection tool helped identify any issues and made the questionnaire run more smoothly. However, a criticism of this approach is that individual questions and their relevance and coherence were not considered, as this was not part of the criteria. Not examining individual questions is a limitation of this approach and study.

Upon reflection, a pilot study should have been conducted prior to conducting the questionnaire. However, this would have been challenging because it could have jeopardised the data collection method for the main study, as it was being shared on social networking platforms. Due to this, it would have been difficult to find out who had already participated in the questionnaire, as on social media sharing is anonymous; subsequently, it would have been difficult to ascertain feedback. This thesis did not want to jeopardise its data collection method. Nevertheless, not conducting a pilot is a limitation of this thesis.

3.7 Dissemination of the questionnaire

Initially, the advert to participate in the questionnaire was 'shared' onto several social networking platforms: Facebook, Twitter, Reddit, and LinkedIn. These are all popular, free, online social networking sites, accessed by many people (Ellison et al., 2007). They were also rated as having many users in the UK (Business Insider, 2015). The questionnaire was publicised by being 'shared' and 'tweeted' on my own social media pages; those who read the post shared in the UK, and some also asked their friends to share. The questionnaire advert was posted on different groups within the social media platforms that were relevant to this study. Links to these initial groups are in Appendix 9. These involved an SBNR Facebook and Reddit group. This was to help attract the intended target audience. For my safety, I made sure that my own social networking profiles did not have my home address or any personal information I did not wish to share.

A limitation of these social networking sites is that the questionnaire was only accessible to people who have internet and were registered on these sites. A group that might be under-represented could be the elderly, as they are less likely to be on social media sites (Hargittai, 2007; Madden and Smith, 2010; Thelwall, 2008). However, it was hoped that a wide enough sample group could be recruited to outweigh the limitations of using these sites. Furthermore, with all these social networking sites, the questionnaire could be 'shared', which means it could be disseminated all over the internet. The link to this study questionnaire could be copied and pasted, so theoretically could be shared by anybody and in several ways, such as email, blogs, and other social networking platforms. Therefore, the benefits of achieving a relatively large sample by these means seemed to outweigh the limitations.

3.7.1 Advert

The advert on social media to attract questionnaire participants was considered in detail. This was to help encourage as many (relevant) people as possible in the UK to participate. The advert consisted of information about the questionnaire. It also made it clear the specific target audience the research was hoping to reach:

Hey There,

*For my PhD, I am looking at the impact of spirituality on people's health. I am especially targeting those who consider themselves to be *spiritual but not religious*' and *healthy*. Please, could you take 20 minutes of your time to contribute to this study? You will be kept anonymous as I do not require your name or personal details. You need to be based in the UK and over 18.*

This message was added to encourage people to participate. On the participant information sheet, it restated that to take part in this research, you need to consider yourself 'healthy' and 'spiritual but not religious.' An incentive prize such as a gift voucher could have been used to encourage more people to participate (Gneezy, Meier and Rey-Biel, 2011). However, there are many legal implications to using an 'incentive', and terms and conditions would need to have been drawn up (Frey and Oberholzer-Gee, 1997; Scott, 1976). There are also issues over the participants giving their true answers instead of trying to provide the 'right' answer that would earn the incentive (Göritz, 2006). Due to this, it was decided that an incentive was not needed for this study. If necessary, posters and flyers could have been used to attract a wider audience.

3.7.2 Process of connecting the questionnaire to social media

The participants accessed the questionnaire by following a link through the advert used to recruit them. The next stage of the process was to ensure that the participants read both the Participant

Information Page and the Ethical Consent Form. They then followed the questionnaire through to the end. As the questionnaire was online (via Qualtrics), the participants' answers were stored as they completed the form. The participants submitted their answers at the end of the questionnaire by pressing the 'submit' button. Qualtrics automatically collects and collates the data. It was impossible to establish how many people clicked on the initial questionnaire, as Qualtrics did not record this information.

3.8 Design of the interviews

Brayda and Boyce (2014), Manning (2012) and Patton (2002) consider interviews a way to become closer to the participants' lived experiences, which is essential to this thesis as it explores people's personal experience of how spirituality influences their health. An informal interviewing design was applied to understand the participant's experiences. It was hoped that the informality helped make the participants feel at ease and more likely to give an honest answer (Novick, 2008; Patton, 2002).

The interview schedule was designed by using Patton's (2002) interview guide to formulating interview questions. An interview guide provides a framework for the questions. 'The guide helps to make interviewing people more systematic and comprehensive by delimiting the issues to be explored' (Brayda and Boyce, 2014, p.320). This included the development of the wording of questions that could address the objectives of this thesis. Patton's (2002) interview guide was specifically drawn upon as it helped to avoid embedding assumptions in interview questions. It is an approach widely used in health research because it is seen as a rigorous way to be unbiased (Roulston, 2017). However, other researchers have also developed interview guides that can be drawn on (for example, Jamshed, 2014 or Turner, 2010 papers). Patton's (2002) interview guide was considered most relevant to this thesis because it was easy to follow and would hopefully provide the knowledge to develop the most robust questions (Brayda and Boyce, 2014).

Patton (2002) categorises six types of interview questions that a researcher can ask. There are (1) experiential and behavioural questions about what a person does or has done. Then there are (2) opinion and values questions designed to understand what people think about some issue or experience. Other queries, known as (3) feelings questions, endeavour to elicit people's emotional responses to their experiences and thoughts. In contrast, (4) knowledge questions seek to inquire what facts the respondents understand. Patton (2002) also states that (5) sensory questions ask about what is seen, heard, touched, tasted, and smelled. Lastly, (6) demographic questions (such as age, education, and occupation) identify the characteristics of the person being interviewed. These categories were taken into consideration when developing the questions for the interviews

Patton (2002) recommends that questions should be asked in a particular order. Opinion and 'feeling' questions can be asked first, while the researcher is probing for interpretation of experience. Next, a researcher may ask knowledge questions as a follow-up. Questioning about the present tends to be easier than about the past. According to Patton (2002), background and demographic questions are boring; people hate these questions and, therefore, researchers should keep such questions to a minimum. Fundamentally, questions should be open-ended, so that people can respond in their own words (Patton, 2002) and be expressive. Questions should also be singular; no more than one idea should be expressed (Patton, 2002). Patton's (2002) approach to interviewing and developing interview questions was followed to answer objectives. As a result, opinion and 'feeling' type questions were first asked for this study, followed by demographic questions (discussed in more depth below).

The interviews were conducted using semi-structured questions, allowing participants to expand answers and receive prompts if required. Structured questions would have limited the opportunity for participants to expand on their answers (Patton, 2002). Utilising the Patton (2002) interview guide, each objective was examined separately to form the question(s) to address it. For objective one (To ascertain the participants` self-perception as to whether they considered themselves healthy or not), there was no need to ask this question, as any participant who had not identified as 'healthy' would not have been invited to be interviewed. This was because they were not the intended target audience of this thesis. Therefore, no questions were formulated to answer objective one.

To meet objective two (To explore the definition of spirituality from the participants` perspective), the interview participants were asked: Do you consider yourself spiritual? And 'What does spirituality mean to you?'. As the literature review identified, 'spirituality' could have various meanings to different people (Clarke, 2009; Hulett and Armer, 2016; Narayanasamy, 2001; Williams and Sternthal, 2007). The point of this question was to further expand on the themes from the questionnaire to address objective two.

To answer objective three (To explore the participants' spiritual practices), the interviewees were asked: 'Have you recently engaged in any spiritual activity?' This question was asked because the literature review identified limited research exploring spiritual practices (Mercadante, 2017; 2020). This question allowed the interview participants to discuss their spiritual practices (if they had any), and it was open-ended so that people could respond in their own words (Patton, 2002). This produced information about spiritual practices in answering objective three.

For objective four (To explore the reported relationship between the participants' spiritual beliefs and their health), the participants were asked: 'How do you perceive spirituality to affect your health?' This question was formulated to directly reference specific dimensions of health in order to address a gap in the research, as highlighted in the literature review. The question was designed to analyse whether the information they presented supported or contradicted the overall questionnaire's findings and provided new findings.

With objective five (To explore whether the demographic factors impact spirituality and the participants' health), the participants were asked about their backgrounds and stated their occupations if they had one. The interview participants were asked for their age, gender, and geographical location (this was also part of deciding the best approach to having the interview conducted). The participants were explicitly asked about their backgrounds because the previous literature identified that individuals' experiences might shape how they perceive spirituality (Clarke, 2009; Jones, 2016). Patton (2002) proposes that asking the participants a general open question at the beginning allows the interviewee to feel in control and non-judgemental questions help to put the participants at ease.

3.8.1 Interview guide

These questions were then drawn together in an appropriate order to develop the interview guide. This was the interview guide:

1) Please tell me about your background.

2) Do you consider yourself to be spiritual? Yes/No If no, why not?

3) What does spirituality mean to you?

4) a) Have you recently engaged in any spiritual activity? (Yes/no)

b) Please, can you expand your answer?

5) How does spirituality influence your health? Can you please give me some examples?

The interview process was designed to enable a deeper understanding of the relationship between spirituality and people's health. To make the process as successful as possible, I followed Bryman (2016) and Kvale's (1996) criteria of a successful interviewer. This involved being a knowledgeable, clear, gentle, open interviewer, who interprets the participants' answers as correctly as possible (Bryman, 2016; Kvale, 1996).

The interviews were designed to be kept to approximately 30 minutes. Seidman (2013) and Woodcock (2017) suggest that this is the average attention span of participants, and they may lose interest if the interview goes on any longer. When the interviews were conducted, verbal or nonverbal prompts (only in face to face or skype interviews) could be given to encourage more complete and better-explained responses (Bowling, 2014; Jones and LeBaron, 2002). The length of each interview was noted in section 4.4. The average was 37 minutes.

3.8.2 Testing the interview guide

The interview guide was tested prior to the collection of data. Pretesting the interview guide is crucial to check the questions and gain some practice in interviewing (Majid et al., 2017; Prescott, 2011). This tends to be done with two participants, one expert and the other a potential participant (Majid et al., 2017). For this study, two people (one researcher and one student) tested the interview guide beforehand by going through the questions and answering them. These two people were specifically chosen because one was knowledgeable in conducting interviews and mixed method research, and the other would have been a potential participant. Based on the Turner III (2010) 'Testing an Interview Guide', these two people were asked: 'Do you consider the questions to be clear and easy to understand?', 'Were the instructions about engaging with the interview clear?', 'do you feel anything should be added to the interview guide?', and 'Does the wording of the questions need to be changed?' These test interviewees gave feedback to see if any changes were required; however, there were none. The two people who tested the interview guide were confident that the procedure was clear, and none of the questions was perceived to be misleading in any way. Turner III`s (2010) approach was chosen explicitly because it is clear, straightforward, and used in other health research.

The interview guide was tested by first recording how long the interviews lasted (one was 25 minutes and the other 20 minutes); second, the location of where the interviews were going to be conducted was also tested (one of the interviews was conducted face to face at the university, the other was conducted online via Skype); third, the recording equipment was also tested (all worked fine); finally, the interviewing style was tested by asking the participants if they were satisfied with the whole interviewing approach and process. The two sample interviews were listened to afterwards to ensure that leading questions were not asked, the recording was clear, and the interview's tone (being used in the interview) was appropriate.

3.8.3 Interview format

The interviews were conducted either face to face, over the telephone, or via Skype. Skype is a telecommunications application software that provides video chat and voice calls from computers, Tablets and mobile devices via the internet (Skype, 2018). Table 21 presents the advantages and disadvantages of all these methods when conducting the interviews.

Table 21: Type of interview format: advantages and disadvantages

Type of interview	Advantages	Disadvantages
Face to face interview	Allows for more in-depth data collection and comprehensive understanding. Body language and facial expressions are more clearly identified and understood. It is easier for the interviewer to probe the respondent; they provide stimulus material and visual aids to support the interview. (Opdenakker, 2006)	They can be more time consuming to recruit and conduct. They can be expensive because of timing and travel. Interviewees can deliver more biased responses because they want to please the researcher due to the pressure of the researcher's presence. (Holbrook, Green and Krosnick, 2003)
Skype interview	People can be recorded in any environment in which they feel comfortable; the researcher can see a person's body language without being physically with them. There is no need for the participant to travel, which can be less expensive and saves time. (Deakin and Wakefield, 2014)	Software and good internet connection are required, thus discriminating against people who cannot afford internet or those living in rural areas where the internet connection may be poor. The appropriate area for interviewing participants might be difficult for them. There is evidence to suggest that appearing on camera can make participants nervous. (Deakin and Wakefield, 2014)
Telephone interview	They allow a certain amount of control over the setting and the environment of the interview. Theoretically, a researcher can speak to anyone in the UK if the participant has access to a telephone. It is a way to enable more inclusivity. (Carr and Worth, 2001)	They do not allow the researcher to see or respond to non-verbal cues. It is visually more difficult to judge if a participant is not telling the truth. It might be difficult for those who are deaf or hard of hearing. (Carr and Worth, 2001)

As identified in Table 21, there are advantages and disadvantages to every interview format. It was decided that a mixture of these interview formats could be used, because using a combination that best suited the participant should enable a wide range of people`s views to be gathered (Fisher, 2021; Opdenakker, 2006; Wilkson, 2021). The participants were offered a choice as to how the interview was conducted. This approach enabled a relatively large number of people to contribute from all over the UK. The variations in using different interview techniques were looked at after the interviews were conducted to see if any significant differences emerged (such as if different themes were discussed); however, there did not appear to be any differences.

At times, 'probes' were used during the interviews to stimulate participants to give more information (Novick, 2008; Opdenakker, 2006). As the participants volunteered to leave their contact details and

wanted to discuss their spirituality, minimal encouragement was needed. Despite this, further questions were asked at times, for example, 'can you please tell me a little more about that?'

All the interviews were audio-recorded with a Dictaphone, the built-in recording device on Skype was also used to record the online interviews, so that the data could be transcribed later. The interviews started a day after the questionnaire closed. In total, twenty-four interviews were conducted. Of these, three were undertaken face to face, ten over skype, and eleven over the telephone. The participants chosen for the interview were targeted through the convenience sample; they had to have reported as both healthy and SBNR. A discussion about how I kept myself safe during the interviews is presented in the ethics section 3.11.5. It should also be noted that an information sheet and the consent form to participate in the interview were sent to all the interviewees (shown in Appendix 11 and 12).

3.9 Sample

A sample is 'a segment of the population selected for investigation' (Bryman, 2016, p.174). The targeted sample for this thesis was people who identified as SBNR and healthy in the UK. This was a requirement for people to participate. As found in the second literature review (section 2.14.1.1), the categorisation of SBNR is not an exclusive term. There were variations within the categories, for example, secularists, atheists, agnostics, and non-affiliated (Mercadante, 2020; Parsons, 2018). An issue with the term 'SBNR' is that it is subjective, and there are variations within the term, making the targeting of the specific population problematic. This thesis wanted to focus on those who solely identified as SBNR, concentrating on the spiritual element, as there have already been many investigations on religion and health (Koenig, 2012; Oman, 2014; Oman and Thoresen, 2005); therefore, it excluded those who identified as religious and SBNR, as the SBNR categorisation in the UK tends to be exclusive of religion (Hastings, 2016; Mercadante, 2017; Smith, 2020) and, generally, those who identify as SBNR take issue with organised religion (Hastings, 2016; Mercadante, 2017; Smith, 2020). A criticism of this approach could be that those who identify as both religious and SBNR are potentially missed. However, a follow-up study could include a hybrid of those who identify as both SBNR and religious.

In addition, this thesis wanted to target those who identified themselves as 'healthy,' because the literature review found that much of the existing research focused on those with specific illnesses or disabilities (discussed in section 2.6.2.1). As a result, this study concentrated on individuals who considered themselves 'healthy,' to address the gap within the current literature. As with the term SBNR, the concept of what is 'healthy' can also be subjective.

In line with how the questionnaire data was collected (online through social media sites), a convenience sample was used for reasons of practicality, accessibility, and increasing the likelihood of targeting the intended audience (Bowling, 2014; Holloway and Wheeler, 2013). A convenience sample 'is one that is simply available to the researcher by virtue of its accessibility' (Bryman, 2016, p.187). The sample was targeted via social networking sites, which can be viewed anywhere in the UK. Using this method ensured that the respondents were not confined to one area, thus making the sample group potentially much more comprehensive and consequently more replicable, as the internet can be accessed by a large number of people (McClean et al., 2019). Using social media sites, particularly those of groups of SBNR, meant the intended sample could be directly targeted.

3.9.1 Questionnaire sampling

This study wanted to attract a large sample to provide accurate data with a representative sample of the SBNR population in the UK. For this reason, an online questionnaire targeting people living in the UK, who identified as SBNR and healthy, had the potential to bring up an array of different experiences and answers. This approach was critical when looking at subjective topics such as spirituality and health, which can have different meanings to different people, especially as this study hoped to generate new research in this area. A larger sample can be perceived to produce more reliable results, with greater precision and power (Creswell and Plano Clark, 2007).

In relation to sample size, Bryman (2016, p.183) points out the question '*How large should a sample size be?* There is no definitive answer'. It was hoped that at least five hundred people would complete the online questionnaire; as McClean et al. (2019, p.30) proposed, 'five hundred is powerful statistically'. Mclean et al. (2019, p.30) also recommend 'aim for the maximum number that is feasible for your given resources'. This was further supported by Bowling`s (2014) suggestion that the larger the sample the better, especially if a large population is being targeted. This can help make the results more accurate and reliable. Five hundred participants seemed like a reasonable target, as research suggests using social media to recruit participants can increase how many people will be gathered (Salganik and Heckathorn, 2004; Wilson, Gosling and Graham, 2012). This number was enough to run some basic statistical analyses with the quantitative data and, at the same time, to gather a wide range of truths with the qualitative results. Therefore, a minimum of five hundred questionnaire participants could provide significant insight into the topic.

However, using a convenience sampling method limits the wider applicability of this research (McClean, 2019). There is also the issue of the questionnaire only being completed by 15–20% of the intended target audience (Brechin, Brown and Eby, 2000; Ellison et al., 2007). As the target sample

was relatively large (five hundred participants), it was hoped it would encourage relevant people to participate and 'share' the questionnaire. This approach was successful. The participant information cover sheet on the front of the questionnaire highlighted that the focus of this study was on those who identified themselves as being SBNR. Participants were required to be aged eighteen or older to take part in both questionnaires and interviews.

3.9.2 Interview sampling

In total, two hundred and thirty-three questionnaire participants were willing to be interviewed. The interview participants were randomly selected by giving each questionnaire transcript a number. An online random number generator was used to select a questionnaire. If the questionnaire fitted in with the interview criteria, an attempt to contact the participant was made. If the participant did not respond (twenty-eight people did not respond) or decided they no longer wanted to participate (which was the case for ten people), the existing questionnaires were then randomly selected for the interview. In total, an attempt was made to contact sixty-two people. Ten people decided not to participate because they were no longer interested in this research or did not want to give up their time due to other commitments. The process to decide how many interviews were enough is discussed below.

Several factors could affect how many interviews a researcher should conduct. This includes: the resources of the study; who the study is targeting; the saturation point, which refers to the point in the research process when no new information is discussed in the data analysis (Faulkner and Trotter, 2017; Saunders et al., 2018); and the researcher's experience, fatigue, and confidence (Patton, 2002; Mason 2010; Ryan and Bernard 2006; Saunders et al., 2018; Seidman, 2013). Existing literature was examined to determine what was an acceptable number of interviews to conduct, with recommendations between 20–30 interviews (Hagaman and Wutich, 2017; Patton, 2002).

Lincoln and Guba (1985) proposed that the sample size can be determined by the criterion of 'informational redundancy', meaning that sampling can be terminated when no new information is elicited by sampling more people. Interview sampling continues until the researcher senses they have reached saturation (Guest, Bunce and Johnson, 2006; Mason, 2010; Morse, 2015). Bertaux (1981, p.37) describes how the researcher is surprised or learns a great deal from the first few interviews. By (say) the fifteenth interview, the researcher recognises patterns in the interviewees' experiences (Bertaux, 1981). More interviews confirm what the researcher has already sensed (Guest, Bunce and Johnson, 2006; Mason, 2010; Morse, 1995). How saturation of knowledge is reached or passed during sampling is uncertain. According to Mason (2010), it is more likely PhD students using qualitative

interviews will stop sampling when the number of samples is a multiple of ten rather than when saturation has occurred. Guest, Bunce and Johnson (2006) found that 12 interviews of a homogenous group are all that is needed to reach saturation. Therefore, as illustrated, there is no agreed number of participants to be interviewed. Considering this all, it was felt that data saturation was reached by the twenty-fourth interview, as by this point, no new information was required.

3.10 Quality criteria for this research

As this thesis was trying to provide insight into the reported relationship between spirituality and health, it was essential that the findings were reliable and conform to high standards. The methodological quality of mixed methods research has long been identified as one of the major issues and debates in mixed methods research, yet rigour and quality are considered essential aspects of a research project (Creswell and Plano Clark, 2017; Tashakkori and Teddlie, 2003). This also links back to the philosophical issue of 'what is truth and knowledge' and how it can be verified. The most appropriate way to decide the quality critical for mixed methods research is still being debated among researchers (Bryman, 2012; Creswell and Creswell, 2018; Moffatt et al., 2006).

Some researchers deal with the issue of judging what is good research by taking the qualitative and quantitative data separately, and assessing them by different criteria which were appropriate to that particular type of data (Bryman, 2012; Creswell and Creswell, 2018; Moffatt et al., 2006). This approach was applied to this thesis, as it fits into the notion of 'quality' of research being both ideographic and nomothetic, and the idea that there is no absolute truth. For the quantitative data, Bryman's (2012) criteria for Evaluation of Research Reliability was applied. For the qualitative research, Lincoln and Guba's (1986) 'Trustworthiness criteria' were used. Their criteria are widely cited in the health field as being a reliable way to access the quality of qualitative research (Bryman, 2012; Creswell, 2013; Tobin and Begley, 2004).

3.10.1 Quantitative - Questionnaire data

Bryman's (2012) 'evaluation of research' consists of three main criteria: reliability, replication, and validity. Bryman (2012, p.41) argues that, for quantitative research, reliability is 'concerned with the question of whether a study is repeatable and whether the measures that are devised for concepts are consistent'.

3.10.1.1 Reliability

Cronbach`s Coefficient Alpha was used to check the internal reliability of the scale in relation to the questionnaire data. This measures the internal consistency, that is, how closely related a set of items are as a group (Tavakol and Dennick, 2011). Cronbach's Coefficient Alpha was used to measure the internal consistency with each dimension of health concerning spirituality (in the questionnaire data). This indicates the average correlation among all the items that make up the scale (Pallant, 2005). Any score over '.7' is considered reliable (Pallant, 2005).

Table 22: Cronbach`s Coefficient Alpha

Number of participants: 759	**Cronbach's Coefficient Alpha**	**Number of items**
Physical health	.881	6
Emotional health	.834	8
Mental health	.802	4
Social health	.925	8
Societal health	.779	3
Spiritual health	.806	6

Table 22 shows that all the Cronbach's Coefficient Alpha scores were over .7, showing internal consistency. This illustrates the amount of agreement between participants who are all using and understanding the same concept in the same way.

For the other questions (in both the questionnaire and interviews), reliability was developed to make sure the concepts were consistent and clear to understand (Bajpai and Bajpai, 2014). This was done by testing the questionnaire design (section 3.6.5) and the interview guide (section 3.8.2). Bryman (2012) and Johns (2010) suggest that reliability could be improved if the target audience and the aim of the study are stated clearly at the beginning of the data collection methods; this thesis adhered to that criterion. In addition, at the beginning of the online questionnaire and on the information sheet, the participants were notified that the results would be anonymous; it was hoped that this would help make the participants feel at ease and answer more truthfully, which would aid reliability.

3.10.1.2 Replication

Replication can occur when the description of the research procedures is clear enough to be replicated by other researchers (Bryman, 2012). This thesis provides clarity on the methods employed. It provides evidence of its approach to data collection and the questions being asked, which would make it easier to replicate this study (Seidman, 2013). The data collection method could be repeated; however, different results might occur if different people participated in the questionnaire and interviews. The data in this thesis was carefully examined for replication within the findings to see if similar answers kept appearing. As Gerrish and Lacey (2006) state, if a pattern emerges, it is reasonable to assume that the results obtained from the questionnaire are reliable. The findings of this research were also compared against previous research to see if there were similarities.

3.10.1.3 Validity

Bryman (2016, p.41) states that validity is 'whether a measure that is devised for a concept does reflect the concept that it is supposed to be denoting'. Bryman (2016) identified two types of validity: internal and external. Internal validity is where the concepts are made clear to the study participants, and external validity is how generalisable the results are (Bryman, 2016).

Internal

For this thesis, internal validity was related to the accuracy of the claims made by the researcher and how these are reported and justified (Bryman, 2012; Bryman, 2021; Jones, 2016). As previous literature identified, spirituality is a nebulous construct (Jones, 2016; Wattis, Curran and Rogers, 2017), which can be difficult to define and locate in Public Health research (Oman, 2018). This presents a challenge for ensuring the validity of the findings and inferences made. The validity of the findings and inferences were strengthened by contextualising the findings within Public Health and the broader literature. This research compared the results (discussed in chapter five) with previous research to help ensure validity. The researcher was very aware that spirituality as a concept is difficult to measure and locate; being explicit about this in the limitations and acknowledging it openly helps to improve validity (Bryman, 2021). Validly was also improved as the triangulation of the results facilitates validation of data through cross verification from more than two sources (Carvalho and White, 1997; Denzin, 1978).

Validity of the questionnaire process

A questionnaire should undergo a validation procedure to ensure that it accurately measures what it aims to do, regardless of the responder (Streiner, Norman and Cairney, 2015). Bajpai and Bajpai

(2014) propose that valid questionnaires (that have been previously tested) help collect better quality data with high comparability, which reduces the effort and increases the credibility of data. The validity of the questionnaire was important to make sure it accurately measures what it is meant to (Kazi and Khalid, 2012). Oluwatayo (2012) argues there are four types of validity: face (Does the content of the test appear to be suitable to its aims), content (Is the test fully representative of what it aims to measure), criterion (Do the results accurately measure the concrete outcome they are designed to measure) and construct (Does the test measure the concept that it's intended to measure). The only one this study was able to show is face validity. A limitation of this study is that face validity is the weakest form of validity, because it only refers to the transparency or relevance of a test: face validity means that the test 'looks like' it will work, as opposed to 'has been shown to work' (Holden, 2010; Oluwatayo, 2012). Despite its limitations, using an online questionnaire was still considered the best approach to conduct data for this research and face validity is still beneficial. The rationale for using this approach was that it is still valid, the questionnaire design (at the time) was considered the best approach to address the aim of this study, as there had been little research in the UK carried out like this (on a specific population) before. Furthermore, this was an exploratory piece of research and part of the rationale for conducting interviews is that this was an opportunity to explore the findings of the questionnaire to make them more robust.

When it comes to internal validity, with regards to both the data collection tools, evidence suggests that some people may not understand multifaceted terms, for instance, 'societal health' and 'social health' (Bury and Bury, 2005; Schmidt and Fröhling, 2000). To help mitigate this issue, a test of the questionnaire design (section 3.6.5) and interview guide (section 3.8.2) was conducted to ensure all the terms used were clear, consistent, and easy to understand. A Cronbach Coefficient Alpha was also conducted to help check consistency with the terms used.

External

For external validity, the research design and the data collection tools could be used with other populations to conduct research to help compare and generalise the findings. The results chapter of this thesis presents the 'missing/prefer not to say' data (specifically with the demographic data) to illustrate the whole data set. The key to achieving validity in Public Health research is the ability to reflect the phenomenon being explored accurately and authentically (in this case, spirituality). This thesis' accuracy and authenticity are strengthened by using detailed data extracts that reflect the participants' language and meanings (Brewer, 2000; Lewis et al., 2014).

3.10.2 Qualitative data - both questionnaire and interview data

To improve the quality of the qualitative data, this study followed the Lincoln and Guba (1986) evaluation criteria. This approach was chosen because it is the gold standard used in qualitative research (Alexandar, 2019; Holloway and Wheeler, 1996; Neuman and Robson, 2007; Thomas and Magilvy, 2011). This was applied to both the qualitative questionnaire and the interview data. Lincoln and Guba posit that 'trustworthiness of a research study is important to evaluating its worth' (Alexandar, 2019, p.2). 'Trustworthiness refers to the assessment of the quality and worth of the complete study, while helping to determine how closely study findings reflect the aim and objectives of the study, according to the data provided by participants' (Alexandar, 2019, p.2). Lincoln and Guba (1986) established the following criteria for developing the trustworthiness of a qualitative enquiry:

1) Credibility: Refers to the confidence in the truth of the data and its interpretation. This can be established by two aspects: first, carrying out the study in a way that enhances the believability of the findings; second, taking steps to demonstrate credibility to external readers.

2) Dependability: Refers to the stability and reliability of data over time. This can be established by being clear on how the study was conducted.

3) Confirmability: Refers to objectivity which is the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning. This can be established by making sure that the data represents the information participants provide, and that the interpretations of the data are clear to the reader.

4) Transferability: The extent to which the qualitative findings can be generalised or be applied to other settings or groups. This can be established by providing sufficient descriptive data, so that the reader can evaluate and apply the data to other contexts.

(Alexandar, 2019)

3.10.2.1 Credibility

A critical factor in ensuring the credibility of research is to identify and describe the participants' responses accurately and correctly (Lincoln and Guba, 1986). Thomas and Magilvy (2011) state that credibility can be linked to rigour, which is a way to establish trust or confidence in the findings of a research study. In previous studies, rigour was established by following a systematic process (such as a systematic literature review) to help inform research. This thesis has mirrored this approach by completing two systematic reviews.

Two different data collection methods were used to ensure the data was credible: questionnaires and interviews. This allowed a wide range of data to be collected and to check for consistency in responses. This also enabled triangulation of the results, which can help remove bias and compare the findings of the two data sets.

In this thesis, the questions were asked as similarly and consistently as possible to all the questionnaire and interview participants. Neuman and Robson (2007) claim that research could be affected by the characteristics of the respondents, such as their memory, knowledge, experience, motivation, and personality. I remained mindful of these influencing factors, which are revisited in the discussion chapter, where the findings are contextualised.

To help establish trust and confidence in the questionnaire findings, the participants filled in the information themselves, therefore collecting the participant's responses and not my interpretation. For the interviews, I conducted and transcribed the interviews myself in order to limit possible transcript errors from the interviews. I also made sure I spent an appropriate amount of time with the participants to ensure the right data was collected, and I used a Dictaphone to record all the interviews; this way, I could listen to the recording again to ensure I was transcribing the correct information. My supervisor also checked a sample of my transcriptions as a form of 'expert checking' to make sure I had transcribed them correctly. Dorussen, Lenz and Blavoukos (2005) claim that experts are more likely to spot errors or concerns, thus helping to contribute towards the credibly of a study. Finally, by immersing myself in the data and ensuring that the data was accurate and representative of what the participants were saying, I was able to help ensure credibility.

The rigour of the data analysis strengthens the accuracy of the inferences made to support the findings, which are reported in the results chapter. To establish this, an even representation of the participants' data was presented. Additionally, the audit trail offered transparency of the decision-making processes throughout the data analysis, such as developing themes and core concepts, further enhancing the rigour of the findings (Jones, 2016; Ritchie and Lewis, 2013). Credibility was strengthened further by using reflexivity to increase the qualitative research studies' quality (Rolfe, 2006).

3.10.2.2 Dependability

Dependability is when the reader and critic of the research can follow a checking process of the procedures used (Lincoln and Guba, 1986). To establish this, there was also an audit trail to help improve the dependability of the study. This study's process has been clearly described and is

transparent, as the design of this research has been discussed in-depth, for example choice of methodology, formulation of the questionnaire/interview questions, and development of the interview guide. Yet, with dependability, there are several possible biases in this study that need to be acknowledged. One of the most prominent is that I, as the researcher, hold my own beliefs and understanding of what spirituality is and how it can impact people's health. Literature suggests that the researcher's age, gender, culture, personality and life experience can also affect the research process, and such biases need to be recognised and acknowledged (Holloway and Wheeler, 1996; Jacob and Furgerson, 2012) (discussed in section 3.14). However, it has been argued that these influences sensitise the researcher to the events and people in the investigation and can, therefore, be a positive resource if researchers are reflexive and aware of their own assumptions (Rubin and Rubin, 2011).

Particularly in relation to the interviews, there is also the issue of 'persuasiveness,' which is the capability of a person or argument to convince or persuade someone to accept the desired way of thinking (Stewart and Cash, 2008). This can affect the dependability of the study. This was dealt with by being mindful of myself as the interviewer and not trying to lead the interview participants. Using a questionnaire as a data collection method also helped to mitigate this bias as I had no direct control I had over how the participants responded.

3.10.2.3 Confirmability

Confirmability is when the data is linked to its sources for the reader to establish that the conclusions and interpretations arise directly from them (Korstjens and Moser, 2018; Lincoln and Guba, 1986). To achieve confirmability, this study was as transparent as possible, particularly regarding the conclusions and interpretations of the results. There was a clear description of the data, design, and methods used. I took steps to demonstrate how my findings emerged from the data, and I attempted to evidence that my own predispositions were avoided as much as possible. This could be seen as being transparent. Previous studies in the literature review helped support/contradict this study's findings, which were used to show confirmability. There was also a clear audit trail.

Confirmability was further achieved by continuous reflection while writing the thesis. In this research, raw and original data were generated and then compared and analysed. Examples of how this was achieved are provided in the data analysis section 3.13. This enabled the findings to be clearly formulated and explains how I came to these interpretations. This confirmability relates to using triangulation of two different data sets to give a deeper meaning to the findings (Korstjens and Moser,

2018). This study's results were compared against previous literature to see how it matched, disagreed with, and even developed previous findings. This thesis attempted to provide new insight and gather a broad range of views to apply this study's results to other research and potentially develop new studies.

3.10.2.4 Transferability

Transferability refers to how the findings can be generalised from a representative sample to the whole population (Lincoln and Guba, 1986). This research aimed to capture a broad range of views but would not necessarily be transferable to a different population. Ritchie et al. (2013) suggest that transferability is when some of the issues raised will resonate with a broader group beyond those who took part. This research aimed to explore and provide insight into how spirituality was reported to influence people's health, which may be useful for additional research and can help to inform Public Health practitioners.

3.10.2.5 Summary

For the quantitative data, reliability, replication, and validity were considered at great length. To further achieve a reliable study, statistical tests were run to show internal consistency within the quantitative data. This study followed Lincoln and Guba's (1986) recommendations on truthfulness for the qualitative data, as they are a well-established and reliable set of guidelines. By using triangulation for these two data collection methods, it was hoped to further enhance the overall 'truth' within the findings. This would ensure that this research was produced to a high standard.

3.11 Ethical considerations

The proposed study was approved in accordance with Canterbury Christ Church University Ethics Procedures on the 6th of August 2015 (Ethical Approval is in Appendix 10). Beauchamp and Childress` The Four Principles of Biomedical Ethics (2013) were utilised to ensure this study considered all the ethical implications. Briefly, the four principles are:

- Autonomy: The right for an individual to make their own choice.
- Beneficence: The principle of acting with the best interest of others in mind.
- Non-maleficence: The principle that above all, one should do no harm.
- Justice: A concept that emphasises fairness and equality among individuals.

While the scope of these Four Principles of Biomedical Ethics is often debated, there is no questioning their canonical status in the field of Public Health (Petrini and Gainotti, 2008; WHO, 2008). Furthermore, from a pragmatic perspective, these four principles were a straightforward way to frame the ethical considerations when conducting this study.

3.11.1 Autonomy

All the participants received a detailed study information sheet, which explained why the research was being conducted and what it would involve. At the beginning of the questionnaire and interviews, a contact email address was clearly displayed and given to the interview participants to provide clarity and ongoing support, if necessary, throughout the study. To further address any consent concerns, the participants in this study freely self-selected to participate in the questionnaire and interviews. They were also able to withdraw at any time without providing an explanation (Foster-Turner, 2009). The participants left their contact details on the questionnaire if they were happy to have a follow-up interview. Those who did not want to be interviewed by the researcher did not have to leave their contact details.

3.11.2 Beneficence

Throughout this thesis, it was integral to act in the participants' best interests and generate new insights for the research community. The focus was not on improving participants' lives but on producing new insights into how spirituality might impact the health of those who identify as SBNR. Some of the participants reported that they benefited from having time to explore their thoughts around their spiritual beliefs. This thesis hoped to develop a new understanding which might be useful to others and the research participants in the long term. The participants were made aware in the questionnaire and interview collection process (see Appendix 11 and 12) that their participation and the resulting research findings might help current and future research.

To ensure that the participants were treated beneficently, measures were in place to avoid any adverse consequences (Beauchamp and Childress, 2013). For instance, if an interviewee became distressed by the questions being asked, the interview would be instantly terminated. However, none of the interviews in this thesis were terminated. I remained neutral and respectful throughout, and if there were any concerns (during the interviews), they would be terminated immediately. Termination was the standard protocol (Black et al., 2006; McCosker, Barnard and Gerber, 2001; McSherry, 1995). As previously stated, at the beginning of the questionnaire and interviews, a contact email address

was clearly displayed and given to the interview participants to provide clarity and ongoing support, if necessary, throughout the study. This can also relate to non-maleficence.

3.11.3 Non-maleficence

The study design acknowledged that spirituality could be an emotive and sensitive issue and might cause distress to the questionnaire and interview participants (Beagan and Kumas-Tan, 2005; Jones, 2016). Again, the interviews would be terminated if anyone became upset, and information about where to get support was provided. The information and consent paperwork detailed how this would be dealt with and reiterated the participant's right to withdraw at any stage.

Every participant was made aware that their data would remain confidential and secure. This was explicitly stated in the copy of the information sheet/ consent form for the questionnaire and the information sheet/consent form for the interviews (Appendix 11 and 12). All electronic files, such as consent forms, questionnaires, notes, transcripts and coding frames, were saved and stored in a master file which was kept on a secure password-protected computer, to which only I had access. Hard copies of consent forms, questionnaires, and transcripts were kept in a secure cabinet, in a locked room, within a securely locked building at the university. All interview recordings were also saved on a secure password-protected computer and labelled with a number, date and descriptive title (for example, 01_11.09.15_particpant1). All personal identifiable data (name, names of relatives or friends, references to location) were removed from transcripts and, where appropriate, a pseudonym was used. Any printed data stored in a locked cupboard will be destroyed after the study. In line with university regulations, data will be securely stored for up to five years on the university shared drive upon completing the thesis (CCCU, 2017).

3.11.4 Justice

To ensure participants were treated fairly, all participants were asked the same questions in the same manner. Everyone had the same chance to participate and was treated the same way. All the participants' information was treated with respect, for example, by not speaking about participant personal data to other respondents and anonymising any identifiable data. It was hoped that this study's insight would contribute to new knowledge in the long term.

3.11.5 Researcher safety

With regards to sharing the questionnaire and using social media, I made sure that no personal details about myself were shown on social media. While conducting the interviews (in any format), I did not disclose any personal information apart from my name and university email address to protect my safety. To ensure the face-to-face interviews were conducted in a safe environment, they all took place on university property, in a room with windows and a wide door, so that if the participant chose to leave at any time, they could do so freely and easily without having to provide an explanation (Bryman, 2016); it also meant that I could leave if I felt my safety was threatened.

Woodcock (2017) proposed that 'the researcher should ensure that someone knows where you are going and what time to expect you back'. To follow this advice, I ensured my supervisor knew when and where the face-to-face interviews were being conducted and when they had finished. Trochim (2006) and Woodcock (2017) recommend that researchers should agree with a colleague or friend on what to do if they do not return when expected and have not contacted them. This advice was followed, and a mobile phone was kept on my person when conducting the interviews. This advice was also followed for telephone and Skype interviews, but any concerns could be reported to my supervisor. If the participants said anything that raised a concern, the interviews would be quickly terminated. However, this was not required in this study.

3.12 Procedures

The order of the data collection process was as follows:

Questionnaire data

1. The questionnaire was created and uploaded on Qualtrics.
2. Ethical approval was approved.
3. The questionnaire was uploaded onto all the social networking sites.
4. The questionnaire remained on social networking sites for three months. Research showed that this is an appropriate amount of time to allow people to participate; beyond a certain amount of time, people lose interest and reach saturation point (Gerrish and Lacey, 2005).
5. The questionnaire was 'shared', and a reminder to fill in the questionnaire was posted regularly.
6. The questionnaire was closed.
7. The questionnaire data were then analysed.

Interview data

1. The interview schedule was created.
2. Ethical approval was applied for and approved at the same time as the questionnaire.
3. The interviews were conducted over three months.
4. The interviews were transcribed over six months.
5. The interview results were analysed.
6. The questionnaire and interview data were then combined.

3.13 Data analysis

Creswell and Plano Clark (2018, p.209) 'Data analysis in mixed methods research consists of analysing the quantitative data separately using quantitative methods and the qualitative data using qualitative methods'. Furthermore, 'It also involves combining both databases using approaches that mix, or integrate, the quantitative and qualitative results' (Creswell and Plano Clark, 2018, p.209). The results from the questionnaire were only analysed after the interviews had been conducted; this was to prevent any bias towards the interview findings. However, once the interview data had been collected, the questionnaire data were analysed first. I did not want to analyse the questionnaire data before the interviews had been conducted, because I did not want to leave the iterations of data collection too far apart from each other, as there was a possibility that some people may lose interest and not engage in the interviews due to how the participants were recruited.

A convergent design approach was used to 'mix' the data of this study. A convergent design data analysis is where the researcher 'first analyses the information separately and then merges the databases' (Creswell and Plano Clark, 2018, p.221). This approach was chosen because a convergent design intends 'to develop results and interpretations that expand understanding, are comprehensive, and are validated and therefore confirm the findings' (Creswell and Plano Clark, 2018, p.119).

The quantitative questionnaire data was analysed first, followed by the qualitative questionnaire data and, finally, the qualitative interview data. The qualitative findings were then used to confirm, disconfirm, and expand the quantitative data. The interview data was used to add more depth to the questionnaire data. Different data was analysed in different ways, in order to address the research objectives (discussed in more detail below). The similarities and differences in the findings are presented in the discussion chapter, and the interviews were used to further expand on the results. The purpose of this convergent design was to develop an understanding of this topic, provide

comprehensive results, and confirm the findings of a different data set (Creswell and Plano Clark, 2018).

To provide clarity on how each of the data sets were analysed, this next data analysis section is presented in the following order: first, the methods by which the quantitative questionnaire data was analysed; followed by the qualitative questionnaire data analysis and the interview data; finally, how the results and data were brought together, with a discussion about how the results were presented.

3.13.1 Quantitative data analysis

The quantitative data was inputted into the Statistical Package for the Social Sciences (SPSS) version 25 (https://www.ibm.com/support/pages/how-cite-ibm-spss-statistics-or-earlier-versions-spss), which is a software package used for statistical analysis (Argyrous, 2011). For this study, SPSS was an efficient way to manage a large data set, as it facilitates the emergence of frequencies and correlations. It also enables graphs to be created and trends to be found so that the data can be more easily understood (Norusis, 2008). SPSS helped generate routine descriptive statistical data for question responses, such as frequency counts of closed questions and distribution of multiple-choice question responses. The data was arranged in the same order as the objectives. Different statistical tests were run depending on the question to be answered.

For the quantitative analysis, prominently descriptive statistical tests were used to describe the data set. Hayes and Smith (2021) state that descriptive statistics summarise and describe the characteristics of a data set. The descriptive statistics used in this thesis included standard deviation, the average, and minimum and maximum statical variables. Cronbach's Coefficient Alpha test (an inferential statistic) was also used in this thesis. Different questions underwent different analyses; for example, each one of the health dimensions (physical, emotional, social health); the mean scores, average scores, and standard deviations were generated. This thesis did not use other inferential statistics (a statistical method that deduces the characteristics of a bigger population from a small but representative sample). The descriptive statistical analysis sufficiently answered all the objectives of this research. For example, for objective three (To explore the participants` spiritual practices), the descriptive statistics were able to show the frequency of the engagement in spiritual practices and where they engage in spiritual practices. Therefore, inferential statistics were not required in this thesis.

3.13.2 Qualitative data analysis

A thematic analysis approach was used to analyse qualitative data. Thematic analysis is 'a method for identifying, analysing and reporting patterns (themes) within data' (Braun and Clarke, 2006, p.79). There are many ways to conduct a thematic analysis (such as Alhojailan, 2012; Boyatzis, 1998; Javadi and Zarea, 2016). Although there was no massive variation over these thematic approaches, Braun and Clarke's framework was chosen because it was flexible and accessible (Bryman, 2021). It has also been refined over the years and used in many other studies to thematic analysis data (Braun and Clarke, 2020; Bryman, 2021; Lorelli et al., 2017).

Braun and Clarke's (2006) Six-Step Framework for conducting a thematic analysis was used for this study. The six steps are: 1) Become familiar with the data; 2) Generate initial codes; 3) Search for themes; 4) Review themes; 5) Define themes; 6) Write up. This thematic analysis approach was chosen because it is a flexible and relatively straightforward approach to analysing qualitative data (Braun and Clarke, 2006; Braun and Clarke, 2013). One of the advantages of this type of analysis is its theoretical freedom, which means it is not restricted to one way of thinking (Braun and Clarke, 2006; Braun and Clarke, 2013). It therefore fits well into the pragmatic framework. Bryman (2016) points out there are criticisms of a thematic analysis approach as, arguably, the researcher might be biased and miss other relevant emerging themes. I was aware of these issues and endeavoured to capture anything of importance. With this approach, I tried to be consistent the whole way through by using the same approach, thematically analysing all the data in the same way.

Before the thematic analysis could be commenced, I transcribed the interview data, as this allowed full immersion in the data (also adding credibility). Transcribing all the interview transcripts meant I knew the data well and that, in my mind, they were transcribed 'correctly,' in line with what I believe the interview participants were trying to express. As mentioned before, the interviews were semi-structured, and all the participants were asked the same questions in the same way. This made it easier to separate the transcript data into the question and objectives it was answering.

For **step one,** I became familiar with the data by reading and re-reading the answers. I organised the qualitative questionnaire data by keeping the questions separate. The participants' answers were organised in alphabetical order so that it was easier to group the themes together. In the same way as the qualitative questionnaire data, I separated the answers out into each question it was addressing for the interview data.

I inputted both the interview and questionnaire data into NVivo Pro 12 (https://www.qsrinternational.com/nvivo/support) computer software, which is a qualitative data

analysis package (McNiff, 2016). NVivo Pro 12 helped to speed up the process of generating connections and identifying trends that allowed conclusions to be formulated (Bazeley and Jackson, 2013; Gibbs, 2002); it was also a useful tool for assisting with the interpretation of results (Jackson and Bazeley, 2019; Saldaña, 2015). Originally, I kept the interview and questionnaire qualitative data separate and analysed the data set separately, and then brought the findings together. The interview data were analysed separately from the qualitative questionnaire data because it was used to expand on the finding and see how they relate to the questionnaire participants' results.

Step two was the process of coding the data. Coding is labelling and organising qualitative data to identify themes (Medelyan, 2021). It was also possible in Nvivo Pro 12 to do a word count of all the similar words that kept arising, which helped contribute to the developed themes. Depending on the question, both deductive and inductive coding was used. A deductive approach involves coming to the data with some preconceived themes (Caulfield, 2019). An inductive approach involves allowing the data to determine the themes (Caulfield, 2019). For all the qualitative questions in the questionnaire, inductive coding was used. The only question that used deductive coding was questionnaire question eleven ('How does your spirituality affect each health dimension?'). Deductive coding was used for this question by exploring pre-set themes arising from the literature review (discussed in Table 23). These were specific areas this thesis was interested in exploring. For the interview data, in the same way as the qualitative questionnaire data, inductive coding was used for all of the questions apart from question five ('How does spirituality influence your health? Can you please give me some examples?'). In this case, deductive coding was used because particular aspects of health were searched for.

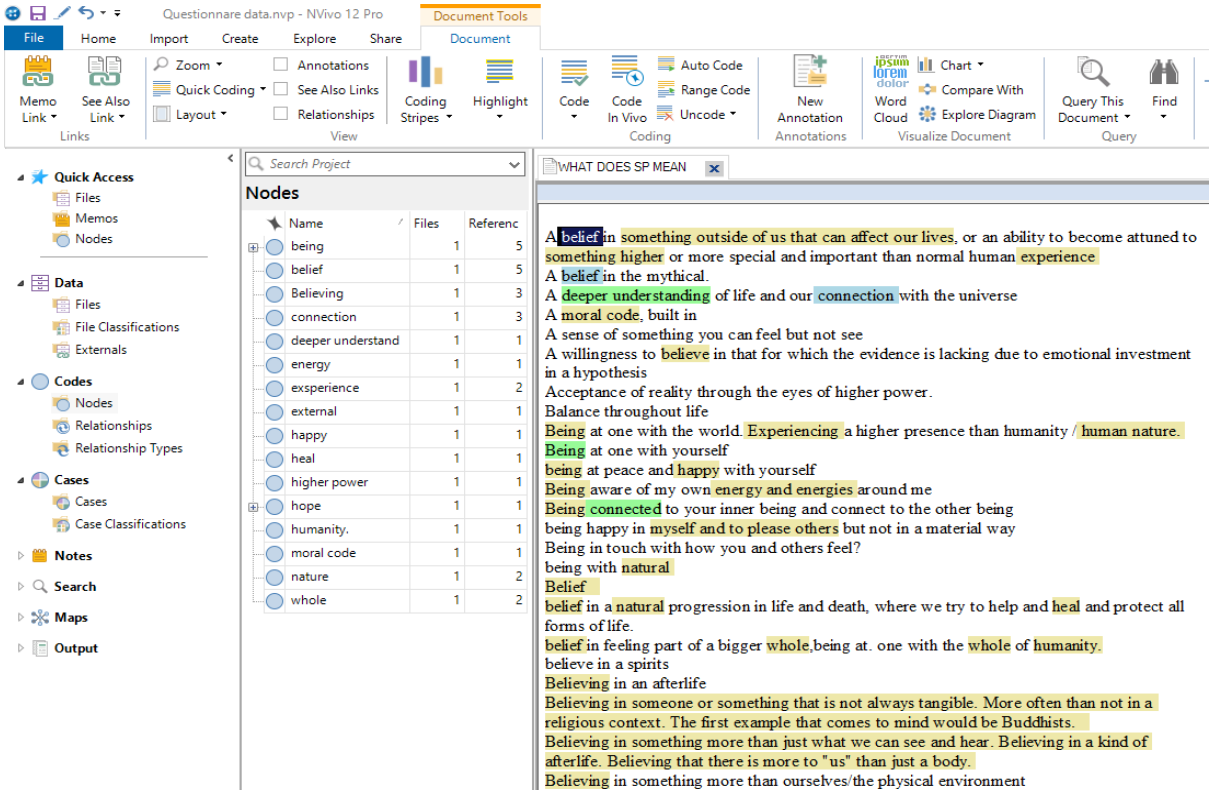
Inductive coding

I did not have pre-set codes for the inductive coding, but rather developed and modified the codes as I worked through the coding process. I started by organising the data in a meaningful and systematic way. To give an example, I used inductive coding for the responses to the question *"what does spirituality mean to you?"*. The initial codes were highlighted and presented in Figure 8.

Figure 8: Inductive coding of the data

Selected extract of the first initial open coding which I undertook for the question

"what does spirituality mean to you?" (questionnaire data)



For the qualitative answers where the questions were only one-word answers (such as questionnaire question six: 'Please state what these spiritual activities are below?') I put the participants` answers into alphabetical order and grouped them together. I then used the 'word count' function in NVivo Pro 12. This way, I was able to count how many participants had given a similar answer. I was then able to categorise them into broad themes. I worked through the participants' responses, coding every segment of text that seemed relevant to or specifically addressed the research question.

Deductive (pre-set) coding

For questionnaire question eleven ('How does your spirituality affect the following?'), the pre-set codes derived from the literature review included 'physical health', 'diet', and 'exercise'. A full list of deductive codes is presented in Table 23, including all the synonyms used.

Table 23: Pre-set themes/words searched for from each dimension of health

Physical health	**Emotional health**	**Mental health**
Physical Fitness Exercise Illness sick Diet Sleep	Emotion Emotional Joy Mood Self-Esteem Happy Happiness	Mental Communication Concentration Think Clearly Stress
Social health	**Societal health**	**Spiritual health**
Social Family Partner Friend Friendship	Engagement Community Safety safe Belonging	Spiritual Belief Activities Feeling Connect Peace

These pre-set codes were developed from the Scriven (2017) dimensions of health. This was to help relate the findings to the specific area of health the participant was discussing. This approach was used to save time and help guarantee that the areas of interest were coded (Medelyan, 2021). However, this approach also creates the issue of bias within the data, as there is a bias with predefined codes as to what the answers will be (Medelyan, 2021). To ensure that no important themes were missed, I attempted to be open to new findings within the data set, and I was mindful of any additional themes that could develop.

To illustrate how deductive coding was undertaken, below is a selected extract of the first initial deductive coding which I undertook for the question 'How does spirituality influence your health (interview data)':

*'So, I think that spirituality impacts not just **emotional** health, but also impacts people's **physical** health, or make you want to engage with friends, or **diet**.'*

This quote above highlights the pre-set themes that were searched for within the data (the words highlighted in bold). Some of the initial codes identified included 'emotional', 'physical', 'friends', and 'diet'. The pre-set themes highlighted areas where these particular topics have been discussed.

Coding ambiguous terms

For all the qualitative data, ambiguous terms such as 'being' and 'a being', which can have more than one meaning, were coded separately to reflect this. Therefore, it was possible to have more than one code in some segments of the data. Within the data, different codes were checked to ensure

consistency in the interpretation of the codes that had a relevant or similar meaning, by checking the context of where the initial code had come from.

Step three was identifying the themes within the results (in both deductive and inductive data). These were developed from the codes found. Braun and Clarke (2006) explain that there are no strict rules about what makes a theme. In this thesis, a theme is a pattern that captures something significant or interesting about the data and/or research question. A theme might represent an underlying concept that involved codes potentially expressing what the participant was trying to convey, or it could give meaning to similar codes with divergent content by pointing directly to the inconsistency (Guest, MacQueen and Namey, 2011). I examined the codes, and some of them clearly fit together into a theme. For example, in the 'definition of spirituality' qualitative section (question six), I collated the following into an initial theme: 'holding a belief,' 'connecting with others,' and 'self-development'. This led to the development of the more predominant themes 'belief', 'connection', and 'self'.

For **step four**, when reviewing the themes (in both deductive and inductive data), I modified and developed the initial themes that I had identified in step three. I made sure every theme made sense and was true to the data. I gathered all the data together that was relevant to the appropriate theme. Maguire and Delahunt (2008, p.3358) suggest that, at step four of the thematic analysis, it is necessary to ask: *'Do the themes make sense?' 'Does the data support the themes?' 'Am I trying to fit too much into a theme?' 'If themes overlap, are they really separate themes?' 'Are there themes within themes?' 'Are there other themes within the data?'*

I made sure that the themes made sense and the data supported the themes. In some sections, a few of the themes overlapped (for example, in the question where the participants were asked to define spirituality). I dealt with this by asking myself these questions and then re-themed some of the initial codes. This is how the initial themes changed to prominent ones. Subthemes within the more significant themes were also formed. I did note relationships between the themes, which I will discuss in the results section.

For **step five,** the defining of the themes aimed to 'identify the 'essence' of what each theme was about' (Braun and Clarke, 2006, p.92), what each theme encompassed, and how they related to each other. Carpenter and Suto (2008) suggest that names of themes must be concise, punchy, and immediately give the reader a sense of the theme. I defined the themes for the qualitative data by using the participants' answers to define themes. For example, the theme 'self' was defined as a: '*person's essential being, thus distinguishing them from others, emphasising introspection or reflective action'*. These quotes are taken directly from what the participants were saying.

With the interview data, the themes were finalised in the same way as the qualitative questionnaire data. The interview themes were used to support the finding in the results section, and differences were also noted. For example, the theme 'self' was found in both sets of data. At times the interview data was also able to further expand on the quantitative results when not discussed in the data. A final thematic map was generated (Figures 9 and 10), illustrating the relationships between themes. This map was developed by bringing both sets of qualitative data together. The interview data was used to support the themes found in the qualitative data. For the last step, **step six**, I wrote up the findings and then presented them in the results chapter.

3.13.3 Merging the results

After the three data sets had been analysed separately, the results of all data sets were then brought together. The quantitative data was considered the foundation of the research; the qualitative questionnaire and interviews helped provide greater depth to the answers and increased an understanding of the reported relationship between spirituality and health from the perspective of SBNR people in the UK.

In this thesis, any discrepancy in the findings was considered in the discussion chapter. There were times when the data showed disparities in the findings, such as when the quantitative data was negative, and the qualitative data could be perceived as positive. However, as the purpose of the qualitative data was to expand on the quantitative data, overall, the qualitative data tended to support the quantitative findings. In addition, further analysis was achieved by integrating some of the literature review findings in the discussion chapter.

3.13.4 Presentation of the results

Creswell and Plano Clark (2018, p.226) state there are two options for representing the integration of results generated by a convergent design: 'a side-by-side comparison' (meaning the data is presented alongside each other) or 'joint display' (meaning the data is merged together). For this thesis, the results were organised side by side. The merging of this study's results was completed narratively. Each section of the results chapter presents the quantitative results first, followed by the qualitative questionnaire results and the interview findings. Most of the quantitative data is presented in Tables, and the qualitative analysis is presented underneath. The findings build on each other to provide a comprehensive picture of the data and new insights.

3.14 Reflexivity

Reflection and reflexivity are integral to health research, to acknowledge and avoid bias in the study design as the researcher adopts a position of 'empathetic neutrality' (Ormston, Spencer, Barnard and Snap, 2014, p.22). 'Empathetic neutrality' means working with the study participants and seeking various understandings without judgment (neutrality) by showing openness, sensitivity, respect, awareness, and responsiveness; in observation, it means being fully present (Mindfulness) (Merriam, 2009). Reflection and reflexivity serve distinctly different purposes and are explored in separate sections of the study reported in this thesis. Reflexivity is positioned in this chapter as it acknowledges the methods of sustaining the study's reliability. A reflective account is presented at the end of this thesis (Appendix 14). A reflection considers the completed study and my personal and professional journey. The purpose of these accounts is to improve the study and further development for practice education and research (Bassot, 2016).

Reflexivity is the continuous process of self-reflection in which researchers engage in order to generate awareness about their actions, feelings, and perceptions, for example while designing the research project and during data collection (Anderson, 2008; Darawsheh, 2014; Finlay and Gough, 2008; Rolfe, 2006). The rationale of reflexivity is to acknowledge the subjectivity of the researcher and improve transparency in the researcher's subjective role, both in conducting research and analysing data; it allows the researcher to apply the necessary changes to ensure the credibility of their findings (Finlay and Ballinger, 2006; Gilgun, 2006). It was essential to be explicit about how my assumptions could influence this research and how I dealt with the issues that arose. This could subjectively compliment how my background, values, and beliefs affect this thesis.

Conducting reflexivity

There is no agreed method for conducting reflexivity (Brewer, 2000; Mauthner and Doucet, 2003). The following section presents the reflexive processes structured in chronological order: pre-research, study design, data collection, and analysis.

3.14.1 The impact of the researcher (pre-research)

Before conducting this research, I acknowledged that there are several ways my own personal bias could impact this thesis. I was mindful that I was looking at 'spirituality' and 'health' through my own lens as a Public Health practitioner/researcher. I recognised my position and background as a white woman with dyslexia in the western world, educated in the British academic system (as discussed in section 1.1). My background shapes my understanding of the world and how I perceive others to

understand the world. As Griswold (2012) points out, this is true for everyone. Bassot (2016) supports this by recognising that people have different understandings of the world; this helps me be explicit in how this could affect this thesis. I tend to view spirituality positively as my own experience is positive, but I recognise that not all feel the same. I acknowledge this and have been mindful of this throughout my research by trying to retain a critical stance and focus on the objectives of this study.

It was decided early on that, where appropriate, I would acknowledge 'me' (first person) within this thesis; writing in the first person helped to acknowledge my subjective impact on the data and allowed a more adaptive approach to what was being discussed, as well as recognising 'me' within this research. However, predominantly it has been written in the third person, as this allows for a more critical Public Health stance; a traditional Public Health thesis is normally written in the third person (Engao, 2021). The strength of adopting this flexible approach in my writing allowed my positionality as the researcher to remain fluid and responsive to the data, while at the same time addressing the research objectives.

3.14.2 Study design

To make my stance explicit to the reader of this thesis, different research paradigms were discussed and a rationale regarding why a pragmatic approach fitted best with this research was added at the beginning of the methods chapter. Adopting a pragmatic approach in this thesis, I struggled at times as my approach to worldviews changed; I dealt with this by focusing and ensuring I fully engaged with the study's research questions. For example, with my ontological stance, I had to think deeply about my view on reality (I have rewritten that section at least thirty times). At times, I had to rethink my position, and my own bias, such as my perception of spirituality having a positive impact on health; This might be true for me, but may not always be true for others. This was previously highlighted as not everyone views spirituality as having a positive effect on health (Koenig, 2018; Mercadante, 2014; Mercadante, 2018). Consequently, I was aware of my own bias and the importance of thinking critically when designing this study.

In relation to my ontology and epistemology, I was aware of my own bias by choosing where to place 'my thoughts', for example my understanding of the world. I attempted to hold a pragmatic stance and focused on addressing the objectives of this thesis. However, a limitation of this research could be reflecting my values (Tashakkori and Teddlie, 2003); which is why I made such a conscious attempt to focus on the research objectives.

Following on from the literature review, a limited number of mixed methods studies were identified in this research area. One of the reasons I wanted to conduct a mixed method study was to gather insight with both approaches. I was keen to employ this approach within this thesis, because one of its strengths is that it could produce a more comprehensive, reliable data set and enable theoretical freedom (Creswell and Creswell, 2018). The literature review helped to highlight the gap(s) within the research, which enabled a more critical stance as to why this approach was chosen. It was decided that collecting both qualitative and quantitative data would help enable a more holistic insight into this topic. Although not explicitly documented, I continually reflected and discussed with other peers and my supervisors about my thesis, for example, the best ways to 'mix' the data together or how to present the research findings.

For the design of the questionnaire and interview questions, I drew on the two literature reviews and the concept analysis to help develop the data collection tools. I had to make decisions based on my reading and knowledge about how many and what type of questions to ask. The use of Scriven's (2017) dimensions of health were beneficial to help mitigate any subjective bias, as it provides structure. I used this framework to structure some health questions and to help identify present codes to look out for in the qualitative data when interpreting the results. However, at the same time, I was aware that a critique of Scriven's (2017) approach to health is the absence of any environmental/sexual/other dimensions to health. Despite this, it was considered the best approach because it covers a wide range of determinants of health, and Scriven is widely cited in Public Health research. As a researcher, I acknowledge how these factors might influence research on spirituality. I attempted to be explicit about how my assumptions could affect the questions, which is why I drew on the literature to help develop the design of the data collection tools.

3.14.3 Data collection

The methods employed appeared the most appropriate to address the questions in this thesis. The online questionnaire seemed to be the most suitable method to collect a wide range of participants' answers; it can be a reliable way to collect data, as every participant is asked the same question in the same manner. I also tried to reduce my impact by being mindful of my position throughout. I also tried to not ask leading questions when collecting both the questionnaire and interview (Parker, 2004). I also tested the questionnaire and interview design to help reduce this bias.

From a Public Health perspective and my own experience, I was aware of the benefits and limitations of using a questionnaire (discussed in section 3.5.1) and interviews (discussed in section 3.5.2) as data collection methods. However, testing the questionnaire and interview design helped highlight any

fundamental issues (discussed in more depth in sections 3.6.5 and 3.8.2). One of the issues I came across was deciding the most appropriate place to share the online questionnaire to reach the intended audience. To deal with this, I did some research on SBNR Facebook groups in the UK. However, once the questionnaire was online, I had little control over that form of data collection. Thus, this is one of the benefits of using an online questionnaire as a data collection method. I was aware of targeting the appropriate audiences; therefore, the questionnaire was shared on relevant web pages. A limitation of this approach meant that it might attract extremist views or not an even representation of those who are not on specific social media sites or have seen the questionnaire (Parker, 2004).

For the interviews (the second data collection method), I was conscious of the importance of not asking leading questions and being respectful to the interview participants (especially as they had given up their time to assist with this research). After each interview, I reflected on ways I could have improved the interview process (such as when to pause and how to get the best out of the interviews), but generally, they were conducted well, ran smoothly, and gathered the essence of the participant's contribution.

I was also aware of the importance of avoiding data bias in the data, such as one of the issues with bias, especially acquiescence (within the interviews), which is when friendliness bias occurs when a respondent feels inclined to answer a question positively or agreeably (Shah, 2019). I tried to mitigate this, by asking non-leading questions, and I made sure I presented the results as they were from the data.

Furthermore, as much as I asked these participants to share their thoughts, feelings, and experiences, the process of the interviews could be perceived as the participants receiving something back, such as the time to explore their thoughts (Peredaryenko and Krauss, 2013). They had not only someone interested in what they had to say, but also someone who was valuing their opinions and listened to them sympathetically. Applying a reflective approach to the experiences throughout this study strengthened my understanding of, and capacity to, recognise personal bias. This involved my ability to remain focused on the task of addressing the research questions, while balancing my interests in their answers. Reflective analysis was crucial at this stage to manage any specific problems with the interview process (Parker, 2004; Shah, 2019). For instance, how the rapport between the participants and myself developed throughout the interviews, with an opportunity to adopt an appropriate level of involvement.

3.14.4 Data analysis

For the quantitative data analysis, this was far more straightforward because it only consisted of analysing the quantitative results. I was mindful of my impact when analysing the data, as I interpreted the data and presented both the quantitative and qualitative results. Predominantly, when analysing the qualitative data, I did not want to create 'confirmation bias', which is when common and highly recognised bias that occurs when researchers interpret the data to support their own beliefs (Shah, 2019). Researchers may also omit data that does not favour their own beliefs (Shah, 2019). I attempted to avoid this by using Braun and Clarke's Thematic Analysis approach when analysing the qualitative data, as well as a mixture of inductive and deductive coding. This also helped me not to have preconceived assumptions about what was going to be found within the results. I was also bound by answering the objectives of the data, which helped to stay focused on the task at hand.

To be clear, one of the limitations of the questionnaire (and the interviews) is it produced masses of data that needed to be grouped, even though SPSS and NVivo pro helped as answers could be grouped and quantified. However, this took a lot more time than I had previously hoped. This meant that this project took longer to complete than I had hoped.

Upon reflection, I would have reconsidered using a validated spiritual tool within the questionnaire, as this would have enabled me to compare the quantitative data against previous studies. I would have explored more demographics in-depth and conducted further analysis to see if there were any differences in the demographic data. However, this was not the focus of this thesis. Furthermore, when it came to data analysis of the interview data, I noted one of the ways it could have been improved. For example, I could have asked the interview participants for more details about their demographic data. The strength of conducting interviews was that I was able to explore the topic in-depth. A limitation of conducting an interview is that they are quite time-consuming. My reflections include the topics they discussed; the length of the interviews could have been a bit shorter. I possibly could have reached data saturation earlier. Nevertheless, Faulkner and Trotter (2017) note that deciding when to stop conducting interviews is always challenging. Upon reflection, I would have spent more time thinking about what 'spirituality is', and how to discuss/present it within this thesis.

Once I collected all the data (there was a lot!), I realised I could not present it all, so I was selective in what was most relevant by directly addressing the objectives of this thesis and, where appropriate, making sure the presented data was representative of the participant's answers. At this point, I was also starting to see that there were themes within the data and that it was better to present the questionnaire and interview data in one chapter. Initially, I was going to present the questionnaire

data and interview data as separate chapters. However, it seemed more appropriate to merge the two chapters to show how the results related. I achieved this by, where appropriate, adding the missing data to show all the findings. I achieved this by adding the missing data to show all the findings where needed.

3.14.5 Summary

I was aware of the impact that I could have on this research, and I tried to stay as open-minded as possible. I tried to remain empathically neutral throughout and mindful of my own thoughts and ideas. I thought critically about the strengths and weaknesses of each approach adopted and the decisions made. The methods used in this thesis were most appropriate for this study to achieve the 'best' answers to produce new insights. Adopting a reflexive approach allowed me to bring together my thoughts and reflect on issues that arose and how I dealt with them. Reflexivity also showed how my thoughts changed throughout (such as presenting the data together and the enormity of the data set) the process. Finally, the explicitness in my approach was strengthened by the reflexive practice adopted, which helped to reduce and be clear about any research bias.

3.15 Chapter summary

The methodology employed by this research was designed to gain as much insight as possible into the most rigorous way to explore how those who identify as SBNR perceive spirituality to impact different dimensions of their health. This research aimed to provide insight into the relationship between spirituality and health. This thesis applied a pragmatic approach using existing literature when coming up with the research and data collection questions, the study's design, and the collection and analysis of the data. This study used a mixed methods approach, collecting both quantitative (questionnaires) and qualitative (questionnaires and interviews) data. The questionnaire data were collected first, followed by the interview data. Three different data sets were collected: one quantitative and two qualitative sets.

Once the design of the questionnaire and interview data schedule was complete and ethical approval had been granted, the questionnaire was placed online. The participants were recruited through several different social networking sites. Those who filled out the questionnaire were asked to leave their email address if they did not mind being contacted for a follow-up interview. A great deal of attention was given to ethical considerations, which have been addressed. The sample size and procedure of this study was also discussed. The quality of research methods and data analysis was also considered to ensure this study was both rigorous and trustworthy.

The data was analysed in the following order: first, the quantitative questionnaire data, followed by the qualitative questionnaire and interview data. The analysis of the quantitative questionnaire data provided a wide range of information from a large sample of people. The qualitative data provided an opportunity for confirmation and disconfirmation and a further exploration of the participants' answers. Collectively, these approaches provided a rich and detailed data set.

Reflexivity was also considered. For example, the methods by which the findings could potentially have been influenced within this research have been acknowledged, including my role within this study regarding the data collection and analysis process. Finally, it is the purpose of this thesis that the approach adopted within this methodology section was the most coherent and efficient method to address this study's overall aim and objectives. It was robust enough to generate new insights within the discipline (which may be able to be applied to practice) and to further the understanding of the reported relationship between spirituality and health.

Chapter Four

Results

4.0 Introduction

The following chapter presents the results from the questionnaire and interview findings, which have been designed to address the following research objectives:

1) To ascertain the participants' self-perception as to whether they were healthy or not.

2) To explore the definition of spirituality from the participants' perspective.

3) To explore the spiritual practices of the participants.

4) To explore the reported relationship between the participants` spiritual beliefs and their health.

5) To explore whether demographic factors (specifically gender, age, education, income, ethnicity and place of birth) can impact spirituality and the participants' health.

This chapter is organised into eight main sections: 4.1 presents the characteristics of the participants and their health status; 4.2 discusses the themes of spirituality; 4.3 examines the results of the participants' spiritual practices; 4.4 considers the reported relationship between the participants' spiritual beliefs and how, for some, it influenced the dimensions of health; 4.5 presents a thematic map of the relationship between spirituality and health; 4.6 reveals the relationship between the participants' demographic factors, spirituality, and health; 4.7 offers the missing data; and, finally, 4.8 provides a summary of the findings.

The findings build on each other to produce an array of insights and provide a more comprehensive picture of the reported relationship between spirituality and health, leading to two thematic maps being created; the first thematic map presents the themes of spirituality (Figure 9). A second map was formed by the identified themes which were perceived to affect health. The first map (Figure 9) was then integrated with the second map, which led to the development of the Spiritual Health Effects Map (SHEM) (Figure 10).

4.1 Initial response rate from the questionnaire

1253 (100%) of the respondents started the questionnaire. 201 of the participants (16%) did not complete more than the first two questions of the questionnaire. Their responses were removed because their data was incomplete. 127 (10%) of the participants identified themselves as members

of a religious group and, as this study was aimed at SBNR people, their data were also excluded from the analysis. 7 (1%) people did not 'agree' to the study consent form, so their responses were removed and destroyed.

917 (73%) completed the questionnaire and agreed to the study consent form. 825 (90%) of the questionnaire participants considered themselves to be spiritual, 47 (5.1%) did not, and 45 (4.9%) were unsure. When asked whether they considered themselves healthy, 759 (83%) of the questionnaire participants answered that they did, 54 (6%), were not sure, and 104 (11%) stated that they did not. Therefore, this left 759 participants who identified as both spiritual and healthy (from the questionnaire).

4.2 Inclusion and exclusion of specific results

As this research focused on those who identified as both spiritual and healthy, the results of these **759 online questionnaire participants** are included in this results chapter and the rest of this thesis. As one of the research objectives, the findings from unhealthy and spiritual participants are singularly included in section 4.5 in order to explain why these additional participants considered themselves unhealthy. The rest of the data set sets out the findings from participants who identified themselves as spiritual and healthy. Conversely, data from all **24 interview participants** were included in this results chapter as the participants had to be both spiritual and healthy to be interviewed.

4.3 Explanatory notes

Throughout the results section, to help differentiate between the different sets of data, the questionnaire participants are referred to as 'questionnaire participants', and the interviewees are referred to as 'interview participants' or 'interviewees'. Additional details of the demographic information in the interview data are provided in parentheses. Due to the large quantity of data generated, it is impossible to include data from all the questionnaires and interview transcripts, but illustrative excerpts of the data are presented.

Quotes that best represented the general participants' most relevant answers were selected. With the qualitative data, there were more positive answers than negative ones. It would appear that the questionnaire participants were more likely to leave a positive qualitative response rather than a negative one (specifically in certain areas of health). They did not tend to leave a comment to explain why.

In this chapter, the words presented in italics are quotes from the participants. The themes of spirituality are highlighted in quotation marks to help show how these factors relate to health. It

should be acknowledged that the results presented are the participants' perceptions of effects on health, rather than measurable physiological effects.

4.4 Information about the participants

This section provides an overview of the questionnaire and interview participants and discusses the participants' health status.

Overview of the demographic characteristics of the questionnaire participants

In terms of the questionnaire demographic, more females than males participated in the questionnaire, totalling 59% (n=448) over the 33.5% (n=254) that were male. There was a number of participants who preferred not to say their gender, totalling 6.8% (n=52), and 0.7% (n=5) chose the 'other' option. The majority (n=688; 90.7%) of the participants were aged between 18 and 65, and only 35 (4.6%) participants reported to be over 66. The participants had a range of educational backgrounds, ranging from no formal education to individuals with an array of qualifications. In terms of employment, over half (n=511; 67.3%) of the participants were employed in a wide range of different settings, and some did not work at all (n=161; 21.3%), and over a quarter (n=87; 11.4%) did not comment on their work status. The participants' income varied greatly, and a large number of the questionnaire participants (n=562; 74%) identified as white British, with 540 (71.8%) of the questionnaire participants being born in England, and other participants originating from Scotland (n=43; 5.7%), Wales (n=17; 2.2%), Northern Ireland (n=14; 1.8%), and outside of the UK (n=58; 7.6%).

Overview of demographic characteristics of interview participants

The interview participants came from a wide range of geographical regions within the UK. Table 24 shows the interview participants' occupations, including such roles as a spiritual leader, occupational therapist, interior designer and teacher, and also those who were unemployed or retired.

Table 24: Demographic characteristics of interview participants

The interviews were conducted from 7th November 2015 to 21st December 2015. The length of the interviews ranged from 25 minutes to 52 minutes and 30 seconds. The average was 37 minutes. Altogether, the total amount of time spent on the interviews was 14 hours and 48 minutes.

Participant identification number	**Gender**	**Age**	**Occupation**	**Geographical location**	**Date of interview**
1	Male	67	Retired spiritualist facilitator	Scotland	7/11/2015
2	Male	55	Practicing spiritualist leader	Queensferry, Wales	9/11/2015
3	Male	45	Life coach	Durham	9/11/2015
4	Female	45	Mother	Liverpool	10/11/2015
5	Female	55	Homoeopath	Leeds	12/11/2015
6	Male	45	Travel Consultant	Cornwall	13/11/2015
7	Male	57	Spiritual leader	Oxford	17/11/2015
8	Female	38	Lecturer	Kent	17/11/2015
9	Male	61	Teacher	Manchester	17/11/2015
10	Female	48	Reiki practitioner	Wales	18/11/2015
11	Female	29	Traveller	Belfast	18/11/2015
12	Male	57	Department manager	Coventry	19/11/2015
13	Male	28	Researcher	Reading	20/11/2015
14	Female	55	Spiritual healer	Stratford-upon-Avon	23/11/2015
15	Male	55	Support worker	London	24/11/2015
16	Male	23	Meditation teacher	Isle of Wight	24/11/2015
17	Female	31	Lecturer	London	27/11/2015
18	Male	35	Interior designer	Liverpool	15/12/2015
19	Female	62	Shamanic healer	Armagh	16/12/2015
20	Female	55	Occupational therapist	East Sussex	17/12/2015
21	Female	50	Student	Kent	17/12/2015
22	Male	55	Tai chi practitioner	London	18/12/2015
23	Female	29	Student	Hull	21/12/2015
24	Female	35	Currently unemployed	Essex	21/12/2015

Table 24 illustrates that most of the interviewees were over 40. The mean average age of the interview participants was 46.5. The interview participants may reflect a higher engagement with spirituality and thus also reflect the significance they place on it. There was an even number of male and female interview participants.

4.5 Health of participants

Objective one: To ascertain the participants' self-perception as to whether they were healthy or not.

Out of the original 917 data set, when asked whether they considered themselves healthy, 759 (83%) of the questionnaire participants answered that they did, 54 (6%), were not sure, and 104 (11%) stated that they did not. The main reasons for people identifying themselves as 'not healthy' fitted into three themes:

- Long-term illness or disease (n=48, 46%), for example, multiple sclerosis or diabetes.
- Mental health issues, for example, stress, depression, anxiety (n=22; 21%).
- 'Unhealthy' lifestyle choices, for example, being overweight (n=10; 10%), lack of exercise (n=10; 10%), smoking (n=9; 9%) or poor diet (n=5; 5%).

16 questionnaire participants reported having various health issues, such as being *'overweight and a smoker'; 'Joint problems and depression', 'I have type 2 diabetes, epilepsy, and I have chronic fatigue-like symptoms'* and *'Long-term mental illness and hypermobility.'* These were categorised into themes as shown above (in the unhealthy lifestyle choices). One of the questionnaire participants described themselves as not being healthy due to being '*old*' and another due to living in an '*unhealthy world'.*

7 of the questionnaire participants did not comment on why they reported they were unhealthy. None of the questionnaire participants' answers were more than a sentence long. Participants would not be invited to participate in the interviews if they did not identify as healthy and spiritual.

After these frameworks for inclusion were established, results of participants who identified themselves as unhealthy, and not spiritual were ultimately excluded from the rest of the analysis.

4.6 Themes of spirituality

Objective Two: To explore the definition of spirituality from the participants' perspective.

In this particular section, the participants were asked what spirituality means to them. A common theme in the 759 questionnaires was that answers tended to be no more than three sentences long, and tended to also be supported by the interview data; as illustrated below.

4.6.1 Definitions of spirituality identified by the participants

Some of the participants had no personal definition of spirituality and were confused about what spirituality meant. Other participants appeared to have a deep understanding of spirituality and offered a clear definition of what it meant to them. The varying definitions of spirituality offered by the participants included broad definitions with commonalities about the self, belief, and personal experience. For example, one of the questionnaire participants defined spirituality as: *'Belief in something outside of us that can affect our lives, or an ability to become attuned to something higher or more special and important than normal human experience. It's part of my sense of identity!'.*

To further support this, one questionnaire participant defined spirituality as: *'A connection or sense of self that looks beyond what they can physically see in themselves and others; perhaps in tune with ideas relating to the soul rather than the body.'*

Another questionnaire participant also echoed this by saying: *'For me, it is a conscious effort and desire to be the best person I can be, connect with others, seek knowledge and ask questions, beginning with why I am here and what is my purpose and values.'*

The interview participants did not shy away from discussing their beliefs and seemed to relish questions about spirituality and what it meant to them. Their answers were far more extended and in-depth because the interviews gave them an opportunity to discuss their thoughts in more detail. For example, interview participant 6 described spirituality as: *'believing in a higher power, believing in Karma, believing that we can connect on a very different level than just talking to one another or connecting physically. I think that the world as a whole is connected spiritually between each other, and I believe that every action has a consequence. And it's believing in something other than yourself, it's believing that there's a really good healing energy out there and if you connect to it there's a higher consciousness, that's what spirituality means to me'* (male, aged 45, Travel Consultant).

Interview participant 21 defined spirituality as: *'Well, I was doing your survey, and I was thinking 'do you know what?' This is really hard, and like I sort of believe in the good bits, like you know there are*

all these religions and stuff and all of these rules and things, but I don't agree with those. I just, I think being spiritual is just like being a really good person and being aware of who you are and how you're being, and connecting and being with other people' (female, aged 50, Student).

This was further echoed by interview participant 24: *'It's mainly just wellbeing, you know, physical, emotional, spiritual wellbeing really, a complete package I think for me, meditation plays a big role and that was a really big part of my journey*' (female, aged 35, Unemployed).

A few of the questionnaire participants found it easier to state what spirituality was 'not'. An example is in the following response from a questionnaire participant:

*'Spirituality is **not** religious as such, but a belief in something beyond human. Personally, to me, it is more the belief that things will always come right for you in the end if you do right by others, I guess a little like karma.'*

A further example: *'To be open and free to all and express and learn in a way that is **not** restricted. It is about being connected to others and **not** restricted by rules.'*

These responses demonstrate how some of the questionnaire participants found it easier to articulate their understanding of spirituality by referring to what lay outside the bounds of the concept rather than directly describing what it did mean to them. Related to this, several of the interview participants also noted the difficulty in defining spirituality. For example, interview participant 8 stated that it was: *'hard to verbalise what the term meant'* (female, aged 31, lecturer).

In the questionnaire's written answers, only 20 out of 759 (2.6%) of the questionnaire answers stated that spirituality meant 'nothing', and 6 (1%) were 'not sure' what the term spirituality meant. Two interview participants discussed difficulty defining spirituality by stating: '*It's a fuzzy term'* (Interview participant 11 female, age 29, Traveller). Interview participant 15 commented: *'It is difficult to define what it means? It certainly means being nice to each other and finding similarities rather than things to argue about*' (male, age 55, Support Worker).

4.6.2 Thematic map of spirituality

To illustrate how specific themes were extrapolated from the data, a thematic analysis of the participants' answers (which arose from the questionnaire and interviewees' data) in relation to their 'definition of spirituality,' was developed into six overarching themes. As discussed in section 3.13.2,

an inductive approach was used to theme the data. The themes were developed from the participants` responses, for example, using an extract from interview participant 6 answer:

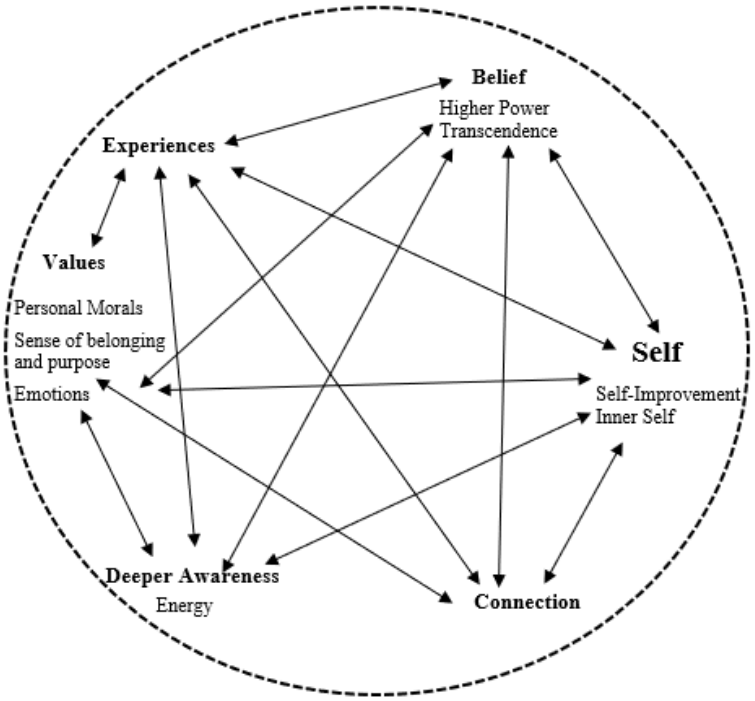
'Believing in a higher power, believing in Karma, believing that we can connect on a very different level than just talking to one another or connecting physically. I think that the world as a whole is connected spiritually between each other, and I believe that every action has a consequence. And it's believing in something other than yourself, it's believing that there's a really good healing energy out there and if you connect to it there's a higher consciousness, that's what spirituality means to me.' (male, aged 45, Travel Consultant).

From this example, the keywords that continually emerged were 'believing', 'higher power', 'connected', 'healing energy' and 'higher consciousness'. These keywords and others were repeated in other responses in the questionnaire and interviews. These keywords were seen as connectors, often indicating causal relationships (Braun and Clarke, 2006). Nvivo Pro 12 provided the option to do a word count of all the similar words that kept arising, which helped the development of the themes. Once the keywords were collected and grouped together, the findings showed that six main themes emerged to define the concept of spirituality; similar responses were pre-grouped together. For example, 'higher power', 'higher consciousness', and 'transcendence', which would then come under the theme of 'belief'.

The findings show that spirituality was a broad concept that comprises six themes: connection, self, beliefs, values, deeper awareness and experiences. These led to the development of the thematic map of the themes of spirituality (Figure 9). The participants' answers (as shown in section 4.6.1) often discussed more than one theme that indicated a causal relationship (Attride-Stirling, 2001; Patel, 2018). Thus, this was used to help inform the development of the thematic map.

Within these main themes, eight sub-themes were identified. There were two subthemes in the 'self' theme: 'self-improvement' and 'inner self'. There were two subthemes for 'belief': 'believing in a higher power' and 'transcendence'. There were three subthemes within the 'values' theme: 'personal morals,' 'sense of belonging and purpose,' and 'emotions.' For 'deeper awareness', there was only one subtheme: 'energy'. The connection theme did not have any subtheme. Figure 9 shows the relationships between the themes which arose through the thematic analysis.

Figure 9: Themes of Spirituality



In Figure 9, the circle around the themes is represented by dashes and is semi-permeable, to signify the movement in and out of spirituality. It is a closed model in isolation, but semi-permeable (as it allows movement of other themes, which may not have been identified yet, as this was only exploratory research) and evolving. The arrows illustrate the themes that are related to each other. The smaller words under the more significant themes are the subthemes.

There is a relationship between the themes, as 'self' is attained through experiences that can be 'connected' to other people or other beings, such as animals or the environment. Deeper awareness is a deeper understanding of what lies beyond material existence and transcendence. There is an intrinsic relationship between these two themes, as they each relate to the individual's perception. All these themes are equally important, yet for some participants, some specific themes had more of an impact than others. For example, for some participants, 'a connection with others' was considered a more critical theme than 'deeper awareness'. Whilst there is room for variation within these themes, they capture the essence of how the participants understand spirituality.

The six themes

This section presents details about the six themes. When discussing spirituality, many participants tended to discuss more than one theme. For clarity, in relation to what the participant was saying, the part most relevant to the theme is presented instead of the full quote. The themes are presented in order of prominence.

Theme one: connection

A 'connection' was conceptualised by the participants in their relationships with themselves, other people, animals, and their environment. This involved a broad range of complex relationships, as shown by the following quotes from the questionnaire data: *'An interconnected relationship to myself and the world about me'; 'A relationship with others'; 'A relationship with every being in the world*'. Spirituality was often seen as an all-encompassing and multidimensional relationship and connection with others and with the world.

Within the interview results, spirituality was consistently described as being an interconnected and holistic concept. To illustrate this point, interview participant 10 stated: '*It's something that can be seen as connected, holistic and complete'* (female, aged 48, Reiki Practitioner). This was further echoed by interview participant 19 who asserted that: '*spirituality can be seen as something that is connected to everything and everyone*' (female, aged 62, shamanic teacher).

Theme two: self

This theme refers to 'inner-self' (who I am) and 'self-development' (improving the self), highlighting an individual essential being, thus distinguishing the self from others, and emphasising introspection or reflective action. For some, spirituality was reported to be part of people's individualism as well as being a means to improve themselves. 'Self' in this sense includes what the questionnaire participants defined as: '*a sense of self', 'self-improvement,' 'self-growth*', '*self-development and contentedness'*. The interview participants also defined 'self' (within the content of spirituality) as being about self-importance and the development of the self. Interview participant 13 stated: *it's about self-importance and development'* (male, aged 28, researcher). This was also supported by interview participant 22 who detailed: *'my spiritual journey is the development of the self* (Male, age 55, Tai Chi Practitioner).

The subtheme 'inner self' refers to an individual's personal, internal identity. An internal identity can be distinct from those defined by external social forces and relationships. The questionnaire participants described it as: *'development of the inner self*'; '*the personal inner internal identity*', *'part*

of personal growth' and *'self-development'*. Those who were interviewed also spoke about: *'fulfilment by oneself of the possibilities of one's character or personality'* (Interview participant 12, male, aged 57, department manager) and *'part of my personal growth and inner-self'* (Interview participant 14, Female, aged 55, Spiritual Healer).

'Self-improvement' was the enhancement and development of a person's knowledge, status, or character by one's own efforts. To illustrate this point, some of the questionnaire participants described spirituality as: *'developing the self', 'deeper understanding of the self'* and *'psychological self-growth.'* This was further expanded on by many of the interviewees, who defined spirituality as *'developing'* or '*growing as a human being*.' To clarify this, interview participant 20 (female, aged 50, student) stated: '*It's to do with self-development and nurturing the soul*'. Another interviewee detailed: '*It's about self-improvement and working towards becoming a better person'* (Interview participant 23, female, aged 29*,* Tai chi practitioner).

Theme three: beliefs

For many of the participants, a theme of spirituality was 'beliefs'. This was understood in the context as something that a person holds to be true, and the responses pointed towards the notion of there being something more to life than the material world. Two different types of beliefs were separated into subthemes: 'believing in a higher/supernatural power' and 'transcendence'.

Many of the questionnaire participants' comments highlighted their belief in a higher power which was not necessarily a 'God': '*A belief in something more than this life*'; '*having hope'* and '*having faith*'. The interviewees also discussed questioning their own beliefs as part of spirituality: *'I am not 100% sure what spirituality is, but for me, it's questioning my own beliefs'* (Interview participant 18, male, aged 35, interior designer).

Interview participant 21 also responded: *'so it's actually given me a whole new perspective on ..... because now I think that we`re all energy and so before my old beliefs so ok you die, and you go to heaven if you`re a good person. And if you don't, if you're a bit questionable, you might go to purgatory, ya know, but now that's complexly thrown out, I don't believe in any of that now. So, I just believe that basically we're energy and that we vibrate and that err, basically it depends on/and where we are in our path that's how high our vibration is going to be.'* (female, aged 50, Student).

The second subtheme was 'transcendence', an experience beyond the material or physical body. This concept was reflected in the questionnaire participants' comments about spirituality being '*beyond human experience'; 'beyond all physical laws'; 'the sense of something mystical*'. This was further echoed in the responses of interview participants 4, 5 and 17, which included the word

'transcendence' when defining spirituality. Specifically, interview participant 4 believed: *'Spirituality is a transcendent experience; for me, it is beyond the normal or physical level. That I struggle to put into words'* (female, aged 40, unemployed). Interview participant 5 discussed how her beliefs were at the core of her spirituality by stating: '*Spirituality means the core of my belief, it's the reason why I get up in the morning and [what I] base moral decisions on'* (Female, aged 55, Homeopath).

Theme four: values

When discussing spirituality, participants often reported their personal 'values' as principles or standards of behaviour as an instinctive element of spirituality. This theme included the participants' personal morals and the notion of being kind to others. This theme had three subthemes: '*morals*', '*having a sense of belonging and purpose'* and '*personal emotions*'.

The subtheme of 'morals' encompasses people's personal rules of right and wrong behaviour, holding or manifesting high principles for proper conduct: '*A sense of duty and being part of something bigger than the self alone,'; 'Helping yourself and others'; 'Helping others'; 'love, peace, unity, respect, treading lightly on earth, loving all people and animals, self-improvement, collective evolution.'*

'Morals' was also echoed in the response by interview participant 2, who answered: *'my morals guide the decisions I make including my health'* (male, aged 67, retired spiritualist facilitator).

Five out of the twenty-four interviewees indicated that part of their definition of spirituality involved their 'morals' and 'values': *'The knowledge that life goes on after death, a set of moral codes to live by, the ability through the spirit to be of assistance to others.'* (Interview participant 1, male, aged 67, retired spiritualist facilitator).

This was also further reinforced by interview participant 15 who expressed:

'*Humanly speaking, we can have a wider range of values than meaning morals. We all live by this guidance but can vary between individuals (sic)* (male, aged 55, support worker).

These findings support the questionnaire results but also highlight how the meaning of spirituality is multifaceted, this was also linked to a person's morals and values.

Another aspect of this theme was the questionnaire participants' feeling of a 'sense of belonging and purpose'. The central part of this values theme is acceptance as a member of a group or feeling part of something: '*Spirituality is looking for a sense of belonging and believing in a 'purpose' to life'. This can guide people's morals and values and feel connected to mother earth'* (Interview participant 12, male, aged 57, department manager). This was further echoed by interview participant 9 who mentioned: *'a sense of belonging, within the community'* (male, aged 61, homeopath).

People's personal 'emotions' were found to be a subtheme of 'values'. Emotions are strong feelings derived from one's circumstances, moods or relationships with others, including feelings such as '*love*', '*happiness*', '*joyfulness*' and '*sense of belonging'*. Other phrases involved: *'Hope and love'; 'Joyfulness'; 'feeling a sense of duty'* and *'knowing that love is the supreme energy and living to help another'.*

Theme five: deeper awareness

The theme of 'deeper awareness' was understood by the participants as something that can lead to transformation through inner thoughts and reflection, mirroring both their conscious and subconscious beliefs. For some participants, it was reported that this was to help change their 'energy patterns' or behaviour to live a healthier lifestyle. In line with this, some of the questionnaire participants' described spirituality: '*Being aware of and connected to the energy that pervades all life.';* '*A feeling that I should try not to harm this planet or my fellow human beings whilst I am here'* and *'feeling a sense of belonging and awareness'*.

Similarly, for some of the interview participants, they could understand the world and themselves on a deeper level through a more profound awareness of the self. For example, one of the interviewees said that spirituality meant: *'Having a higher awareness and being able to reach into the collective consciousness*' (Interview participant 8, female, aged 31, lecturer).

Interview participant 7 further explained this point with the following words: *'The simplest way I can put it is awareness and connection with the universe*' (male, aged 57, spiritual leader). Other interviewees also related spirituality to the notion of 'deeper awareness'. For example, interview participant 3 commented: '*I live at a very high sense of awareness'* (Interview participant 3, male, 45, life coach).

One additional theme that emerged from the interviews was the notion of spirituality as a source of 'energy'. This was categorised as a subtheme of 'deeper awareness'. 'Energy' was the strength and vitality to keep going. In the discussion of what spirituality is, ten of the interview participants referred to a notion of 'energy.' When they were asked what energy means to them, they suggested it was something that exists, yet was hard to measure and verbalise:

'*It's not energy as in physical energy like being awake; it's more like an uplifting feeling. So, when people do talk about religious spirituality, and they talk about feeling a presence, I can understand that because I think that's what spirituality is like. You feel touched almost, that you are in*

contact and you belong, and you've kind of found a balance or an equilibrium in your life that you've hit, certain things are in place, you know?' (Interview participant 17, female, aged 32, lecturer).

Interview participant 6 commented: '*The universal spirit coming on you and that's powerful so I feel that there is something with it, and I feel that if you do good things in your life and you try to get away from sin, and you try and do positive in your life and you think positive, then every negative energy and forces, they can`t drag you down*.' (male, aged 45, Travel Consultant). This 'energy' theme was incorporated into the thematic map of spirituality as a subtheme of 'deeper awareness'.

Theme six: experiences

'Experience' in this context was understood as an event or occurrence which leaves an impression on someone, or a feeling of a supernatural occurrence that cannot be put into words. This could also include the process of doing and seeing things and of having things happen to a person. To illustrate this, questionnaire comments included phrases such as: '*Being at one with nature'; 'Engaging with Nature'; 'Feeling of inner peace'; 'At peace within yourself and others,' 'inner peace and freedom,' Everything, the universe conscious, life'* and *'Everything about us is spiritual that what makes the experience unique'.* Experiences could include some people's spiritual practices, and for others they were '*in the moment experiences'* when engaging in spiritual activities: *'It's a feeling, sometimes when I'm out with my wife I will feel really close to her and everything about her, but I suppose really it's meditation and such!'*

The interview responses also included experiences of spirituality such as '*…feeling at peace when walking the dog'* (Interview participant 5, Female, aged 55, Homeopath). More generally, other phrases mentioned in the interviews were: '*experiencing calm meditation*' (Interview participant 2, male, aged 67, retired spiritualist facilitator) and '*mystical experiences*' (Interview participant 21, female, aged 50, Student). For some interviewees, spiritual practices such as meditation were part of the experience aspect of spirituality.

4.6.3 The definition of spirituality in relation to the literature

Each of the questionnaire participants were also asked to 'identify words or phrases that have any bearing on their own sense of spirituality'. The formulation of this question is discussed in section 3.6.1. In Table 25, the six themes (multidimensional, self-actualisation, connection, a sense of purpose, happiness and love) were identified from both the literature review and concept analysis of spirituality, and discussed with the participants.

Table 25: Phrases that have a bearing on the participants' own sense of spirituality

Which of these words or phrases have any bearing on your own sense of spirituality, if you have one? **n = 759**	**Number agreeing** **n(%)**	**Number disagreeing** **n(%)**
Feeling connected to someone or something outside yourself.	494 (65)	265 (35)
Feeling complete as a	364 (48)	395 (52)
Feeling that you can achieve your full potential.	296 (39)	463 (61)
Having a sense of purpose.	372 (49)	387 (51)
Experiencing a sense of love from someone or something outside yourself.	372 (49)	387 (51)
Experiencing something that makes you feel happy with your life.	402 (53)	357 (47)
None of the above words and phrases are applicable to me.	53 (7)	706 (93)

Table 25 shows the words or phrases that have any bearing on the participants' view of spirituality. 65% (n=494) of the questionnaire participants agreed with 'feeling connected to someone or something outside yourself'. Almost half of the questionnaire participants agreed with the rest of the themes found in the literature. There was some disparity between the findings as not many participants agreed with the themes from the concept analysis and literature review; for example, 'feeling that you can achieve your full potential'. A high number of participants disagreed with this theme.

152 (20%) of the questionnaire participants added additional words to the definition of spirituality. The most common terms were:

- Peace (n=51; 33%).
- Love (n=32; 21%).
- Feeling (n=22; 14%).
- Life (n=18; 11%).
- Connection (n=18; 11%).
- Knowing (n=16; 10%).

Words such as *'connection*' and '*love*' were already listed in the question. However, some of the questionnaire participants rephrased the words slightly differently, for example: '*inner peace and knowledge'* or having a '*higher understanding of life, things such as why we suffer and how to improve one's place in the world.'* This might be due to the phrasing of the question.

The discrepancy in agreement over the phrases identified in Table 25 was perhaps unexpected, considering that some of the themes talked about by the participants when asked 'what spirituality meant to them' (Figure 9) were similar such as a 'sense of connection', 'feeling complete as a person' and 'having a sense of purpose'. Yet when the number of those agreeing in Table 25 could be considered low, this caused some disparity; the results contradicted each other as only half the participants agreed with the phrases presented in Table 25, thus not necessarily supporting the findings in Figure 9. There could be many reasons for this, such as a misunderstanding regarding the question or its wording, or participants viewing their definition as unique to them. Further reasons could relate to participants being reluctant to be 'categorised' similarly to others. To counteract this, the study was led by the participants' own definitions, which were more effective in terms of authenticity and fairness to their idiosyncratic views and representation.

4.6.4 Summary

Both data sets suggest that spirituality was described as a multidimensional concept. In relation to objective two, it was found that spirituality involved part of the self, a belief in something greater than themselves, a connection and personal experience. As mentioned, descriptions of spirituality fit into six main overarching themes: connection, self, beliefs, values, deeper awareness and experiences. Spirituality was reported as having many attributes which enabled connection with other people or a higher power. For some participants, spirituality was perceived as a way to find peace and develop as a person. In contrast, specifically for the interview participants, it was described as being a connected and holistic concept and it led to a higher sense of awareness. For others, spirituality was a method or way to develop a connection to self-growth. Energy, self-development and deeper awareness seemed to be aspects of some people's spirituality. The data suggest there was an intrinsic relationship between the themes. Several questionnaire and interview participants also noted the difficulty in defining spirituality.

4.7 Spiritual practices

Objective three: to examine the participants' spiritual practices

Out of all the questionnaire participants, 417 (55%) stated they engaged in spiritual practices. 288 (38%) participants stated that they did not engage in spiritual practices, and 54;(7%) were 'not sure' if they engage in spiritual practices. Those who answered that they were involved in spiritual practices were then asked about which type of spiritual activities they undertook. The data were categorised by grouping similar activities together. The interview participants` answers also were grouped into these themes. Both the questionnaire and interview participants listed a range of activities. Eight main practices surfaced. With the interviewees, every participant, apart from participant 15, engaged in some form of spiritual practice.

The eight main spiritual practices that occurred were:

1) Meditation
    - 180 (36%) of the questionnaire participants stated: '*Silent Meditation' 'Mindfulness Meditation.*'
    - 15 interviewees stated: *'Meditation' 'I engage with different forms of Meditation.'*
2) Prayer
    - 70 (14%) of the questionnaire participants stated: '*Praying*' '*Praying with others.'*
    - 3 interviewees stated: *'Prayer' 'Praying.'*
3) Yoga
    - 60 (12%) of the questionnaire participants stated: '*Going to Yoga Class' 'Yoga.'*
    - 4 interviewees stated: '*Yoga', 'Yin Yoga.'*
4) Walking in nature
    - 55 (11%) of the questionnaire participants stated: '*Waking in Green Spaces.'*
    - 2 interviewees stated: *'Being with nature,' 'We love walking outside and we climb lots of mountains.'*
5) Going to spiritual places
    - 45 (9%) of the questionnaire participants stated: '*Going to my local holy place.'*
    - 2 interviewees stated: '*Spiritual buildings' 'spiritual shine.'*
6) Giving/receiving healing
    - 40 (8%) of the questionnaire participants stated: '*Chanting*' '*Reiki*' '*healing others.'*
    - 15 interviewees stated: *'Chanting' 'Reiki' 'Homoeopathy and healing.'*

7) Reading
    - 25 (5%) of the questionnaire participants stated: *'Reading' 'Reading spiritual books.'*
    - 3 interviewees stated: *'Reading' 'Reading of spiritual texts.'*
8) Spending time with others
    - 25 (5%) of the questionnaire participants stated: '*going out with my friends.' 'Engaging with other members of the community.'*
    - 4 interviewees stated: '*Spending time with other spiritual people.'*

83 of the questionnaire participants reported that they engaged in more than one spiritual activity for example, meditation and yoga. These were categorised into more than one theme. For this reason, the data total is higher than the number of participants who just stated one activity; this raised the total number of spiritual activities from 417 to 500. The number and percentage next to the spiritual practice above illustrate this. Twelve of the interview participants undertook more than one spiritual activity.

It should also be noted in this section that all the interview participants, except 15 and 23, acknowledged that the spiritual practices were not necessarily activities in the physical sense; they could be more in the 'psyche.' Interview participant 7 commented:

'Yes, I mean, to me, the main spiritual activity is not what's visible externally, but what is happening internally. In that sense, I'm spiritually active all day, every day, you know. It is my life, but that also leads to activities like belonging to a church and ministering to other people. I'm sitting here in a public reading room, keeping it open for the public so that they can come in and find out about these spiritual ideas. So, I consider I have a very spirit-centred life, which doesn't mean I have a trouble-free life. Like everyone, there are challenges, but that is where my heart is.' (male, aged 57, spiritual leader).

This was supported by interview participant 14, who commented: *'It's part of everything I do from washing up to mindfulness'* (Female, aged 55, Spiritual Healer).

This points towards the notion of self-growth. This quote shows how spiritual practices made participant 14 feel that spiritual practices can be part of the mind and not a physical sense for this interviewee. Some of the interviewees said that people turned to their spiritual practices in times when they needed: '*extra support*' (Interview participant 6, male, aged 45, Travel Consultant) or '*a method to deal with a stressful situation*' (Interview participant 16, male, aged 23, meditation teacher).

4.7.1 Frequency and location of engagement in spiritual activities

Table 26: How often participants engaged in spiritual activities

How often do you engage in spiritual activities or practices? n=417	**n(%)**
More than once a day	121 (29)
Once a day	120 (28.8)
A few times a week	91 (21.8)
Once a week	34 (8.2)
Once a month	30 (7.2)
Once every 6 months	16 (3.8)
Once a year	1 (0.2)
Never	0
I am not sure	4 (1)

Table 26 shows that out of the 417 of the questionnaire participants who reported engaging with spiritual practices, the majority of the questionnaire participants (n=241; 57.8%) did so at least once a week, and just under one third (n=121; 29%) reported engaging with spiritual practices more than once a day. The questionnaire showed a wide range of frequencies in engagement in spiritual practices, according to preference and personal circumstances.

Table 27: Locations of engagement with spiritual practices

Where do you engage with spiritual practices? n=417	**n(%)**
Home	172 (41.3)
Outside	104 (25)
In a spiritual/ religious building	50 (12)
Other	91 (21.7)

Table 27 shows that over a third (n=172; 41.3%) of the questionnaire participants engaged with spiritual practices at home, whereas a quarter (n=104; 25%) engaged in spiritual practices outside. 50 (12%) of the participants stated their spiritual practices took place in spiritual or religious buildings. Just under a quarter (n=91; 21.7%) of the questionnaire participants stated that their spiritual practices were located in 'other' places. The other places were categorised as follows:

- Everywhere (n= 64; 70.3%).
- Exercise classes (n=13; 14.3%).
- At work (n=6; 6.6%).
- A friend's house (n=3; 3.3%).
- Countryside (n=3; 3.3%).
- On social media (n=2; 2.2%).

Similar findings were found in the interview data, as three out of the twenty-four interviewees mentioned that they engaged in spiritual practices outside: '*I really enjoy meditating outside'* (Interview participant 13, male, aged 28, researcher) or *'I find my yoga classes at my local village hall are very refreshing'* (Interview participant 22, Male, age 55, Tai Chi Practitioner). The interview participants were not explicitly asked about when and how often they engaged in spiritual practice.

4.7.2 Spiritual practices and health

Spiritual practices were reported to have a positive effect on some aspects of the participants` health. This was not only echoed in the questionnaire data (of those who engaged in spiritual activities). All of the interview participants (apart from interview participant 15) discussed experiencing a positive relationship between spiritual practices and their overall health. These positive effects were divided into four themes: 1) feeling happier; 2) experiencing relief when previously ill; 3) reducing stress and anxiety; 4) perceiving a change in physiology.

Theme one: feeling happier

Some of the questionnaire participants noted that their spiritual practices made them feel happy, content and at peace with the world: '*Meditation makes me happy and is good for my wellbeing.'* Another commented: '*Walking the dog makes me joyful and happy.'* This was further supported by some of the interview participants who described how they perceived the impact of their spiritual practice on their health:

'It's chanting 'nam-myoho-renge-kyo' so that is the chant, and you literally chant it twice a day, morning and evening, for as long as you want to or can. I usually do it for about ten minutes – sometimes it's longer sometimes it's shorter. It makes me happy and feels at ease with the world' (participant 11, female, aged 29, Traveller).

To further support this, interview participant 12 commented:

'It's just meditation, I have done some yoga, but I do need to be careful with my back, so the yoga that I do is, even though I've done it quite a few times, I stay on a kind of like the beginner level. There are things like where I'd be lying on my back, and you pull your leg up to your chest, and then you pull yourself up and, I can't do sit-ups anymore, so I am kind of restricted to that, but yeah it is primarily meditation. However, I move lots when I meditate, and I feel very happy after I'm finished.' (male, aged 57, department manager).

Theme two: relief from previous illness

Several questionnaire participants reported that their spiritual practice had a positive effect on their previous health issues: '*Painting has alleviated my depression.'* Another questionnaire participant commented: *'I just feel good or ask for help'.*

In this section, many of the questionnaire participants also reported that their spiritual practice directly improved their current health status:

'improves wellbeing, peace of mind or soul, healing of body and soul, the advancement of spirit, greater connectedness to others' and another stated: *'Helps me deal with everyday stresses. Helps keep me well and healthy. Spirituality helps to keep me calm and at peace with myself and the world.'*

This was also expanded by interview participant 24, who indicated: '*I feel my yoga really helps my back and muscle pain. I do stretches every day, which relieves a lot of pressure, so I do not get so many headaches* (female, aged 28, unemployed).

Theme three: reducing stress and anxiety

Both questionnaire and interview results showed there were diverse spiritual practices that helped reduce anxiety, varying from tarot reading to meditation: '*A psychic reading of my cards helps to put my mind at rest and tells me I can cope with what life brings'*, while another questionnaire participant made a similar remark about yoga: '*Yoga really helps to reduce my stress and anxiety levels, as it makes me be more reflective and in control.'*

Reducing stress and anxiety was also discussed by interview participant 6, who stated: '*Meditation will help your mental health, as well as greatly reducing stress and anxiety over time. It just takes practice*' (male, aged 45, Travel Consultant). Interview participant 22 noted: *' I think that helps with their kind of health in a way cause I think if you kinda live a good life, and you have positive thoughts I think that you're happier while being here, because if you're going around and your holding onto anger and problems, and holding onto stress and being vindictive, then that takes its toll on your health. That's what I think anyway'* (Male, age 55, Tai Chi Practitioner).

Theme four: A change in people's physiology

A theme that was found in both qualitative data sets was how spiritual practices changed a person's physical body. Within the questionnaire results, several of the participants discussed weight loss: *'Thanks to meditation and yoga, I have lost a lot of weight and feel so much happier';* another quote

to further illustrate this point: *'I started going on purposeful spiritual walks on my own weekly just after Christmas, because of this and a change in diet, I have lost a stone!'*

In addition, with the interview data, a more detailed and far-reaching example of how spiritual activity can be perceived as affecting a range of physical medical issues was provided by participant 19:

'I know on a spiritual level the reasons for these differences, crazy things that have happened to me and I can accept them. I developed a brain tumour, I've had major surgery, I'm now completely deaf in the left ear, and I have no balance. I'm in complete and utter agony in my legs an awful lot of the time as a result of the surgery. Yes, because of nerves and things, and I was told only ten days ago, that I have no dementia, so that's good, but I have a small amount of brain damage.

Ok, that's fine, but I have worked on these issues with my spirits, and I'm comfortable with why. And I understand the reasons with why these things are happening, and that's fine, this is my path to work through, and I can use the GPs as support' (female, aged 62, shamanic teacher).

This participant's response also shows a perception of using spiritual practices as support alongside conventional medical advice.

4.7.3 Summary

The most prevalent spiritual activities both questionnaire and interview participants engaged with were meditation, prayer, going to a spiritual building and giving/receiving healing. Over half the questionnaire participants in this study mentioned that they engaged in spiritual activities at least once a week. The main location that the participants reported undertaking spiritual practices in seemed to be anywhere they felt appropriate. For some of the participants, their spiritual practices were perceived as being beneficial to their health due to feeling better connected, calmer and less stressed. It also made some people feel joyful, content and at peace. One of the findings of this online questionnaire was that many people defined themselves as spiritual, but far fewer actually engaged with recognised spiritual practices. The interviewees reported they engaged in a variety of spiritual practices. Several participants reported that everything they did was spiritual, and some also described how their spiritual practices positively affected their overall happiness and health.

4.8 The relationship between spiritual beliefs and health

Objective four: to analyse the relationship between spiritual beliefs and health.

Table 28: Overall mean scores for each health dimension

Overall mean scores for each area of health		
	Mean	**Std. Deviation**
Physical health	3.9	0.78
Mental health	4	0.83
Emotional health	4.3	0.81
Social health	3.9	0.77
Societal health	3.9	0.79
Spiritual health	4.2	0.77
Total	4	0.79

Table 28 presents the results of the comparison between the overall mean scores of the questionnaire participants in relation to each health dimension. The average mean scores and all of the dimension scores range from 1 to 5. Anything above the midpoint (3) would be considered a positive effect. A score of 1 means a strong negative effect, and a score of 5 indicates a strong positive effect. This table demonstrates the strength of the reported effect between spirituality and the dimensions of health for this study. Out of the scores, anything above the midpoint, 3, indicated spirituality was positively impacting mental health. The total mean score was 4, indicating a strong positive effect on people's health. Within these scores, mental (4), emotional (4.3) and spiritual health (4.2) were reported to have the strongest positive relationship. The dimensions of health which showed the lowest reported relationship were physical (3.9), social (3.9), and societal health (3.9), yet these scores were still above the mean midpoint.

The structure of the results regarding each dimension of health is presented in the following way in the subsequent sections: the quantitative data will be discussed first, followed by the qualitative data. In the discussion of the results of the descriptive Tables 29-33, the two extremes of each side of the Likert scale were combined; for example, '*It has a strong negative effect*' and *'It has a somewhat negative effect'* were added together for the analysis of the results.

The link between the themes of spirituality and dimensions of health was discussed in each section, for example, the six themes of spirituality that were reported to influence the specific dimension of health themes. For physical health for instance, the themes of spirituality that were reported to influence people's physical health were 'self-improvement', 'values' and a sense of 'connection'.

Clarification of the data

It should be noted that those who responded in the quantitative questionnaire data that 'spirituality '*has no effect at all'* or has '*a negative effect'* did not tend to leave a comment in the qualitative section. For example, even though a quarter of the questionnaire participants indicated that spirituality had no effect on their physical health, there was no qualitative explanation as to why. This is a limitation of this study which is discussed in more detail in section 5.7.

35 (3.8%) of the questionnaire participants reported in the comment sections of the health dimensions: *'see above comment'* meaning the same comment applies here. On average, 20% of the questionnaire participants' data was missing as the participants chose not to answer or skipped certain questions. Concerning the qualitative data, some of the themes related to spirituality and health are touched upon, but a more in-depth discussion about the relationship between these themes is featured in more detail throughout section 4.8.

4.8.1 Physical health dimension

Physical health is concerned with 'the mechanistic functioning of the body, which can include overall physical fitness, behaviour, weight, diet, and sleeping patterns' (Scriven, 2017, p.8). The overall mean score for physical health was 3.9 (as identified in Table 28), indicating there was a perceived positive relationship between spirituality and physical health. Table 29 shows that almost a third (n= 172; 31%) of the questionnaire participants reported that spirituality did not affect their physical health, and a small minority (n=41; 2.5%) stated that it had a negative effect. Over half of the questionnaire participants' written answers indicated a positive relationship between spirituality and physical health.

Table 29: The reported effect of spirituality on physical health

Physical health	It has a strong negative effect n(%)	It has a somewhat negative effect n(%)	It has no effect at all n(%)	It has a somewhat positive effect n(%)	It has a strong positive effect n(%)	Overall Mean (SD)
My overall physical health n=744	13 (1.7)	28 (3.8)	172 (23.1)	267 (35.9)	264 (35.5)	4 (0.95)
My general physical fitness n=733	12 (1.3)	30 (3.3)	261 (28.5)	261 (28.5)	169 (18.4)	3.7 (0.91)
The amount of exercise I do n=730	8 (1.1)	28 (3.8)	304 (41.6)	239 (32.7)	151 (20.7)	3.8 (0.88)
Prevention of illness n=730	11 (1.5)	11 (1.5)	216 (29.6)	273 (37.4)	218 (29.9)	3.9 (0.89)
My diet n=729	7 (1)	31 (4.2)	286 (39.1)	248 (33.9)	159 (21.8)	3.7 (0.89)
My sleep n=733	15 (2)	38 (5.2)	187 (25.5)	267 (36.4)	226 (30.8)	3.9 (0.97)

Missing data: 15 (2%) between 30 (5%)

Overall physical health

Table 29 demonstrates that 531 (71.4%) of questionnaire participants thought that their spirituality positively affected their overall physical health. The qualitative data implied this was due to feelings of motivation and self-discipline: *'I am better motivated, regarding exercise and diet'.* Another questionnaire participant remarked that: *Spirituality improves my physical health as it helps to discipline me to live a healthier life by exercising more and looking after myself but also links into not*

wanting to harm the environment, for example, not eating animals which has been beneficial for my overall health and the animals.'

This was also echoed in the interviews: *'My spiritual beliefs lead me to make ethical and environmental choices such as walking to work, which is good for my physical body and the motivation to keep going to achieve my goals! This has massively improved my overall health'* (Interview participant 12, male, aged 57, department manager).

172 (23.1%) of the questionnaire participants reported that spirituality had no effect on physical health (however, the participants did not explain why this was the case), and 41 (5.5%) of the participants stated it had a negative effect on their overall physical health. One questionnaire participant commented that spirituality and health were not related: *'I do not make decisions about exercise or lifestyle choices based on my spiritual beliefs.'*

The interview results confirmed that this effect was perceived because participants' spiritual beliefs motivated them to choose healthy lifestyle behaviours. Several of the interviewees (1, 2, 9, 17, 20) talked about how spirituality affected several aspects of their physical health, as it motivated them to engage with healthier lifestyle behaviours. A secondary effect was on other areas of health, like mental/emotional health; spirituality made people feel calm and less stressed. To demonstrate this, interview participant 20 stated that:

'I think it [spirituality] has a knock-on effect. If you feel calm and less stressed and satisfied and comfortable with what you do, it impacts your physical health. I think you tend to feel better. You perhaps do more because you're more motivated, you'll eat healthily, especially with doing readings and stuff like that. If you clog your body up with junk food, you feel quite sluggish and find it more difficult to get a good connection, so I tend to eat more healthily when I'm doing spiritual work' (female, aged 55, occupational therapist). According to some of the participants in the questionnaire and interviews, this was due to their spiritual beliefs being a way to motivate them, and a method to help prevent them from becoming ill.

Some of the questionnaire participants also reported in the physical health comments section that their spiritual beliefs positively affected their overall general health: *'Spirituality improves my health and wellbeing'; 'Spirituality helps discipline you in taking care of these things'; 'spirituality help relieves symptoms.'* Another questionnaire participant commented: *'I am more likely to lead a physically healthy lifestyle when feeling spiritually happy'.* Another person commented: *'Spirituality guides me*

towards healthy options.' This notion, of being more likely to live a generally healthier lifestyle, was touched upon in many of the participants' answers. This could be partially due to spirituality giving them a deeper understanding of the 'self' and the environment around them, leading to avoiding activities that are bad for their health.

Several questionnaire participants referred to themselves as 'feeling whole' and 'full of energy': '*Feeling connected to life and my physical being makes me want to engage with it and use it, and it feels good to do so. I love being outside, and I love engaging with nature.*' Some of the questionnaire participants reported a connection to the idea that, due to their spiritual beliefs, they have made better lifestyle choices, such as '*…exercising so sleep better.'* and *'yoga helps me sleep and my spiritual beliefs teach me not to eat animals'.* The results suggest this could be an additional effect that positively influences other areas of their health.

Within this physical health section, spirituality was shown to be holistic: *'I see the body as part of the universe, so I take great joy in looking after it through good food, exercise and sleep'*. Another questionnaire participant commented: *'All, holistically our energy bodies are connected, so all, diet, lifestyle, exercise.'* These quotes illustrate how some of the themes of spirituality are connected and relate to physical health.

Four questionnaire participants stated that they felt spirituality had a negative impact, as it can cause overthinking and stress: '*it can cause stresses which leads to poor physical health',* or another questionnaire participant said: *'My spiritual beliefs make me worry and overthink, which causes stress. This can make me lazy and not exercise.'* Eighteen questionnaire participants stated that spirituality did not have any effect on their physical health at all: '*it has no real effect*.' No adverse effect concerning physical health was recorded in the interviews.

<u>Physical fitness</u>

One of the areas in which spirituality was reported to have the least impact was physical fitness. Less than half (n=430; 46.9%) of the questionnaire participants agreed that spirituality influenced individual physical fitness. There were no comments in the written questionnaire data as to why this was lower in comparison to the other health dimensions. However, within the same section in the qualitative data, some of these questionnaire participants commented that their spirituality aids them to live a healthier lifestyle: *'Due to my spiritual beliefs, I eat more healthily, go for lots of walks and make positive lifestyle choices'.* Another questionnaire participant commented: *'My spiritual beliefs have improved my physical fitness as it makes me want to look after myself!'.* This aspect was also

discussed in the interviews *'I lost a stone'* (interview participant 10, female, aged 48, Reiki Practitioner) and *'I much fitter that I was a year ago. Then I started doing Reiki and it`s helped me become healthier and fitter'* (interview participant 16, male, aged 23, meditation teacher).

261 (28.5%) of the questionnaire participants reported that spirituality had no effect at all on physical fitness, and 42 (4.6%) of the participants stated it had a negative effect on their overall physical health. Although less than half of the questionnaire participants thought it did not have any impact, this could be linked to the fact that only half the questionnaire participants engaged in spiritual practices.

Exercise

Just over half (n=390; 53.4%) of the questionnaire participants thought that their spirituality positively influenced the amount of exercise in which they engaged; this aligns with the results that only half the participants engaged in spiritual practices (it should be noted that not all spiritual practices are physical). The qualitative questionnaire data suggested that this was because the notion of 'self-improvement' meant that they exercised more and felt encouraged to go out walking and engage in healthy activities, such as visiting green spaces and undertaking physical activity. It also inspired them to eat healthier foods: '*Due to my spiritual awakening, I do lots of exercises which I never used to'* and another referred to '*being outside and walking in the fresh air*'. The questionnaire participants also commented that they *'walk regularly'* or do *'yoga'.*

Exercise was also discussed at length in the interviews. For example, interview participant 9 described the impact spirituality has on the amount of exercise he gets:

'I think it [spirituality] can be used for people to encourage them to lose weight or exercise more… Also, I have known people who have stopped smoking and given up meat which has made them healthier or choosing a better lifestyle for themselves. I think I can really help people through spirituality by encouraging them to make healthier lifestyle choices.' (male, aged 61, homoeopath).

Interview participant 17 also discussed the link between exercise and spirituality, with the following words: *'Through activities such as mindfulness and yoga, I can cure myself with the power of my mind and positive thinking and exercise'* (female, aged 31, lecturer).

These findings suggest that spirituality was a motivation and a way to improve or encourage leading a more healthy lifestyle; this, in turn, was reported to make people happier and improve their health overall.

304 (41.6%) of the questionnaire participants reported that spirituality had no effect on exercise, and 36 (4.9%) of the participants stated it had a negative effect on the amount of exercise they did. There was no qualitative data to explain why might explain why this was the case.

Prevention of illness

67.3% (n=491) of the questionnaire participants thought that their spirituality positively influenced the prevention of illness. Several of the questionnaire participants referred to their spirituality as a method to help them cope with life issues and/or manage illness: *'Helps with IBS [Irritable Bowel Syndrome]'* another questionnaire participant commented: *'Spirituality helps me relax and maintain my stress levels, which is beneficial to my epilepsy'*; *'I seem to have fewer aches and pains. My general health is improved.'*

Five of the interviewees (1, 9, 17, 19, 24) described how they thought that their spiritual beliefs influenced the prevention of illness by making them 'feel better,' as a method to deal with stress and/or anxiety, or by enabling them to feel in control:

'I think a lot of sickness and illness comes from stress, so I just sort of pull back. One of the reasons that I changed career was [because] I was in the hospital for about six weeks. And I came to understand that I never wanted to go back to the hospital again. And, that the reason I was in the hospital was my life wasn't working, so I've been quite happy and contented since, and I think a lot of people get sick because they're unhappy. So, spirituality has helped me to find a different route to health' (Interview participant 19, female, aged 62, shamanic teacher).

Here, the notion of personal self-empowerment was perceived as preventing people from becoming sick in the first place. This illustrates the importance that spirituality has in some people's lives; spirituality was perceived as a method to deal with illness, and also as a means to prevent illness by giving them purpose and helping them feel grounded.

216 (29.6%) of the questionnaire participants reported that spirituality had no effect on the prevention of illness, and 22 (3%) of the participants stated that it had a negative effect on the amount of exercise they did.

Diet

Over half of the questionnaire participants (n=407; 55.7%) acknowledged that their spiritual beliefs helped to improve their diet and exercise. This was because the questionnaire participants' 'beliefs' encouraged them to eat healthier: *'Due to my spiritual beliefs and moral compass, I eat more healthily,*

and go for lots of walks.' Several of the questionnaire participants also perceived there was a link between spirituality and choosing to engage in healthier lifestyle behaviour, for example, avoiding alcohol and smoking, or adopting a vegan diet. One of the comments was: *'I am now a vegan, and I don't drink alcohol.'* Another questionnaire participant commented: *'because of my beliefs I eat healthier, my blood pressure is now normal, and I am exercising daily.'*

This was further echoed by 9 out of 24 interview participants, who seemed to believe that because of their spiritual beliefs, they ate healthier food and made more ethical lifestyle choices. Interview participant 2 said:

'A significant amount of everything I do is spiritual. You know being very hands-on, talking to patients trying to get into those subject areas. Outside of my work life, my wife is a spiritual healer too, and so much of our lives are lived fairly responsibly about spirituality. We both have very high regard for truth, and all sorts of things from politics to our food purchasing is measured against the ethics that we derive from our spiritual worldviews.' (male, aged 55, spiritualist leader).

This was supported by interview participant 1: *'I have now become vegetarian, for moral reasons as I care about the food I put in my mouth. This also helped me to lose weight and be soo much healthier'* (male, 67+, retired spiritualist facilitator).

These interview participants perceived that their spiritual beliefs help to motivate them to eat a healthier diet and make ethical choices about where they bought food and other products. Some suggested that perhaps opting for a balanced, adequate, and varied diet was an essential step towards a happy and healthy lifestyle. This motivated them to make healthier choices around looking after their body and beliefs. Consequently, for some participants, spirituality was perceived to influence diet.

286 (39.1%) of the questionnaire participants reported that spirituality had no effect on their diet, and 38 (5.2%) stated it had a negative effect. The negative effect on diet was not commented on in the qualitative questionnaire and interview data.

<u>Sleep</u>

Four hundred and ninety-three (n=493; 67.2%) questionnaire participants reported that spirituality positively affected their sleep. Some of the comments proposed that participants' spirituality improved sleep as they perceived that their beliefs made them feel safe and secure: '*because of spirituality. I have a deeper understanding of the world and others. <u>I sleep so much better!</u>*' (Underlining by the participant to indicate verbal emphasis). This was perhaps because having a more profound understanding provided some people with comfort and inner peace.

Some of the comments from the questionnaire participants indicated their sleep also improved as a result of increased exercise: '*I sleep so much better due to walking more.'* Also, another questionnaire participant mentioned: *'Exercising so sleep better because of my spiritual activities.'* These results indicate that spiritual practices, such as walking, meditation, and yoga are perceived as improving the participants' sleep. Twelve of the interview participants described how spirituality had a positive influence on their sleep, and some participants suggested that this was due to greater '*peace of mind*':

'I do sleep better, especially when I've done readings and clearings and things like that: I think because I do a lot of concentrating, I'm tired, but also I get a great (s)ort of sense of relief and happiness that I've helped somebody. That sort of impacts on my sleep, I do sleep better.' (Interview participant 20, female, aged 55, occupational therapist).

Interview participant 24 also noted: *'I now spend more time concentrating on the things that matter, which has really helped with my sleep. I no longer sweat the small stuff and sleep so much better.'* (female, aged 28, unemployed).

Spiritual beliefs were perceived to help put life into perspective and allow people to focus on what is essential. This was shown to give people a sense of purpose and a more in-depth understanding of the self. This, in turn, helped to give some of the participants greater 'peace of mind', which facilitated healthy sleep patterns. Several of the qualitative comments from the questionnaire reported that participants believed they slept better because of increased exercise due to spiritual practices.

A quarter (n=267; 25.5%) of the participants indicated that spirituality had no effect at all and 53 (7.2%) of the participants reported it harmed their sleep. None of the questionnaire and interview participants provided a qualitative answer to why they thought this was the case.

<u>Summary</u>

A great number of the questionnaire and interview participants reported a positive relationship between physical health and spirituality. The findings showed that spirituality motivated people to improve their overall general physical health, encouraging them to make healthy moral and ethical choices. As a result, participants perceived themselves as exercising more, improving their diet and using illness prevention strategies. Several participants perceived that spirituality influenced their sleep, making them feel safe and secure, and participants noted feeling whole, full of energy, and having a positive attitude to their lifestyle due to their spiritual beliefs. However, the participants' views on physical fitness indicated that they did not feel a considerable link between spirituality and

fitness. A quarter of the questionnaire participants thought it had no effect, and a small number thought it had a negative impact on physical health.

4.8.2 Mental health dimension

Mental health is 'the ability to think clearly and coherently' (Scriven, 2017, p.8). For many of the participants, spirituality was reported to have a positive effect on mental health (illustrated in all the data sets). The overall mean score was positive 4 (as shown in Table 28). However, 22% (n=171) of the questionnaire participants said it had no effect on their mental health (Table 30). A small number of participants considered spirituality to be detrimental to their mental health.

Table 30: The reported effect of spirituality on mental health

Mental health	**It has a strong negative effect**	**It has a somewhat negative effect**	**It has no effect at all**	**It has a somewhat positive effect**	**It has a strong positive effect**	**Overall Mean (SD)**
	n(%)	**n(%)**	**n(%)**	**n(%)**	**n(%)**	
My communication n=731	4 (0.5)	28 (3.8)	178 (24.4)	262 (35.8)	259 (35.4)	4 (0.9)
My concentration n=733	5 (1)	30 (3)	215 (23)	272 (35)	211 (36.9)	3.9 (0.89)
My ability to think clearly n=731	9 (1.2)	23 (3.1)	173 (23.7)	256 (28)	270 (29)	4 (0.92)
My stress levels n=733	15 (2)	45 (6.1)	117 (16)	239 (32.6)	317 (43.2)	4.1 (1)

Missing data: 26 (4%) between 28 (4%)

Communication

Table 30 demonstrates that 521 (71.2%) of the questionnaire participants thought their spirituality positively influenced communication. The qualitative questionnaire results demonstrate that this was because they meet and engage with others through their shared spiritual beliefs. Spirituality was shown to create 'connection' and enable communication with others: *'I feel I can now be more open with others and communicate my needs.'* Another questionnaire participant commented: *'I am so, so happy! I love engaging with other members of the community.'*

This was further expanded on in the interviews; interviewees stressed the importance of 'communication' with their personal 'self' and 'connecting' with others:

'I am now more in touch with others and myself, because I have been spiritually awakened. I am so much more aware of verbal and non-verbal cues. Even when you can't understand people necessarily, you all share basic universal commonalities' (Interview participant 13, male, aged 28, researcher).

'Connection' and 'self-improvement' themes of spirituality seem to be the perceived factors affecting health here. An interview participant also mentioned: *'I now understand the vital importance of communication with myself and others, so we are all on the same page.'* (Interview participant 10, female, aged 48, Reiki Practitioner).

Almost a quarter (n=178; 24.4%) of the questionnaire participants stated spirituality had no effect, and 32 (4.3%) stated spirituality had a negative effect on their communication. Three questionnaire participants stated that it harmed their mental health, as they felt '*disengaged with others*.'

Four of the interview participants noted that they felt the need to communicate less with other people and focus more on themselves: '[spirituality] *made me more sociable? I would say no, it's made me more meditative really, and I rely on my thoughts and instincts far more than I used to'* (Interview participant 4, female, aged 40, unemployed). However, those who were less sociable reported being happier in themselves. Both questionnaire and interview participants alluded to the notion that this could be part of self-growth and not needing to engage with others.

Concentration

A large number (n=483; 75.8%) of the questionnaire participants reported that spirituality positively influenced their concentration. Some of the comments suggested that thinking and concentration were linked; this was due to the idea that spirituality can create time for people to think and provide a break, which meant they could concentrate for longer: '*Helps calm me down to think positively about the situation*.' Another questionnaire participant answered, '*Can help decrease stress by thinking of the bigger picture.'*

215 (23%) of the questionnaire participants reported that spirituality did not affect their concentration, and 35 (4%) of the participants stated that it negatively affected their concentration. None of the questionnaire participants commented on how it did not affect or was detrimental to their health. Concentration was not discussed in the interviews.

Clearer thinking

Over half (n=526; 57%) of the questionnaire participants remarked that their spirituality helped them to think more clearly. One questionnaire participant noted, for example: *'I can always find solace in the unity of life; it grounds me and makes it easier to let go of the negative aspects of life. This allows me to think more clearly.*' Another commented: *'My beliefs encourage me to look after myself, which enabled clearer thinking.'* This also further supports the responses regarding concentration.

Three of the interview participants (5, 8 and 17) added to this by suggesting that they were able to think more clearly and not focus on the negative aspects of life:

'I believe in the power of my mind and positive thinking, which makes things clearer in my head.' Interview participant 8 commented: *'Focus on the things that you do want, not the things that you don't want, and my understanding of that now is to do with the law of attraction'* (female, aged 31, lecturer).

Interview participant 5 also discussed: *'When I feel I've got it, everything going your way like you feel you're at the top of your game, you can cope with any negative things that come your way because you're in a good place and everything's very clear, and you could be very calm in the situation. Me and my sister go for a spa break once a year. We do it every year, sometimes more, and for me that's really spiritual cause you've got this calming music, you get away from the internet, your phones, any work whatever, and you just have quality time, quiet time, on water beds just reading.*' (female, aged 55, homoeopath).

173 (23.7%) of the questionnaire participants reported that spirituality had no effect on their ability to think clearly, and 32 (4.3%) of the participants stated it had a negative effect on their ability to think clearly. A few of the questionnaire participants stated that they thought spirituality had a negative effect on their health due to overthinking or being selfish: *'I now sometimes overthink, which causes me to worry more.* Another remarked: '*I only think about me and think less about others now, I focus more on me!'* This shows how focusing on the 'self' can have a negative effect on some people's mental health.

One interviewee discussed the negative effect of overthinking in more detail. They commented that overthinking was shown to cause some people extra stress and a questioning of their whole identity: *'I way, way, way, overthink things now and [I am] always asking the philosophical questions such as am I happy? What is my purpose?*' (Interview participant 24, female, aged 35, unemployed).

<u>Stress levels</u>

Three quarters (n=556; 75.8%) of the questionnaire participants thought that spirituality had a positive impact on their stress levels. Several questionnaire comments suggested that this was due to their spiritual beliefs being used as a catalyst to reduce stress, and to provide comfort and distraction when life becomes difficult: '*Spirituality helps to provide calmness, combats stress'* and *'my spiritual belief calms my anxiety and reduces symptoms of depression'*.

Within the interviews, one theme that kept arising was *'stress'* in people's lives and how spirituality helped them deal with it. Six of the interview participants (6, 9, 15, 17, 18 and 20) noted how their spiritual beliefs were used as a 'coping strategy' against stress:

'*My spiritual beliefs lead me to homoeopathy, and then homoeopathy leads me to Reiki, which is really I think where I want to be now. So, it helps me cope with everyday stresses like other people, bills and sudden life-changing challenges. I find Reiki, along with my other spiritual practices, helps to ground me'* (Interview participant 5, female, aged 55, homoeopath).

Interview participant 17 also said: '*You can cope with any negative things that come your way because you're in a good place and everything's very clear, and you could be very calm in the situation. My sister and I go for a spa break once a year'* (female, aged 31, lecturer).

16% (n=117) of the questionnaire participants indicated that spirituality had no effect at all, and 8.1% (n=60) believed spirituality had a negative effect on their health. The results showed spiritual beliefs to be causing people to stress as it makes them think about philosophical questions, such as '*what the meaning of life is*' or '*what happens after I die? This causes me copious amounts of stress'.* One questionnaire participant said: *'It really makes me question everything!'.* Some of the questionnaire participants discussed the need to go through a negative experience in their life to grow: '*I feel like I have to go through the bad stuff to grow, which can have both a positive and negative effect on my wellbeing'.*

<u>Summary</u>

Many of the participants reported a positive relationship between spirituality and mental health. Participants discussed how they felt able to engage with others within the community, as spirituality has the ability to bring them together with others. The notion of communication within themselves and understanding themselves as a person was highlighted in both data sets. A few of the participants in this study thought that spirituality had a detrimental effect on their mental health, as they felt disconnected and detached from others. This could also be linked to them focusing on the self, which was connected to the participants' inner self, self-belief and self-esteem; not needing to make choices based on pleasing others. Some of the questionnaire participants' comments seemed to show that they felt that their thinking and concentration were improved. This was because they reported that spirituality could create time for participants to think and to have a break, which might contribute to them being able to concentrate for longer. Overall, 22% (n=171 Average) of the questionnaire participants thought that spirituality did not influence their mental health. Only a small percentage (n=40; 19.9% Average) thought it had a negative impact on their mental health.

4.8.3 Emotional health dimension

Emotional health is 'the ability to recognise feelings and express them appropriately, such as coping with stress, tension, depression and anxiety' (Scriven, 2017, p.8). As seen in Table 28, out of all the dimensions of health, emotional health, jointly with spiritual health, had the highest overall positive mean score: 4.3. Only a small percentage (n=89; 15%) of the questionnaire participants reported that spirituality did not affect their emotional health (Table 31).

Table 31: The reported effect of spirituality on emotional health

Emotional health	It has a strong negative effect	It has a somewhat negative effect	It has no effect at all	It has a somewhat positive effect	It has a strong positive effect	Overall Mean (SD)
	n(%)	n(%)	n(%)	n(%)	n(%)	
My emotional health n=732	7 (1)	20 (2.7)	89 (12.2)	233 (31.8)	383 (52.3)	4.3 (0.86)
My joy of life n=734	4 (0.5)	14 (1.9)	102 (13.9)	224 (30. 5)	390 (53.1)	4.4 (0.83)
My mood n=732	7 (1)	25 (3.4)	106 (14.5)	269 (36.7)	325 (44.4)	4.2 (0.88)
My self-esteem n=732	9 (1.2)	24 (3.3)	147 (20.1)	254 (34.7)	298 (40.7)	4.1 (0.92)

Missing data: 25 (4%) between 27 (4%)

Emotional health

Table 31 illustrates that there was a reported positive effect between emotional health and spirituality overall. Many questionnaire participants (n=616; 84.1%) mentioned that spirituality positively impacted their emotional health. The qualitative questionnaire answers suggested that spiritual beliefs helped to keep people 'positive' and 'happy', thus complementing their emotional health: *'It helps me keep myself straight in the head and calm and able to see things more positively and hope for the best outcome or deal with worse outcome and therefore able to enjoy my life and keep my mood and emotional wellbeing up.'*

Another questionnaire participant took a more philosophical approach and talked about:

'Being connected to the Universal life force and understanding the working of Universal energies provides a wider view of the World. And therefore, allows me to experience heightened

feelings of happiness and joy. If I have a day where I do feel down, sad or stressed my spirituality allows me to have a balanced view of my feelings and their causes and the knowledge that nothing is permanent - tomorrow is a new day and I find myself lifted up once again.'

When the interview participants were asked about how spirituality affected people's health, they tended to speak about their emotional and mental health first:

'A way to reduce stress I think, especially meditation, absolutely, really really good to keep yourself relaxed and chilled out and so you know it helps with sleep and just generally not being anxious. This is a good treatment for my mental health.' (Interview participant 16, male, aged 23, meditation teacher).

At this point, interview participant 16 expressed that only the physical aspect was focused upon in conventional medicine and not the whole person. He was discussing how the mind and body relate to each other. Also, note how this participant used the word '*treatment'* as an indication of coping with mental illness.

Interview participant 1 commented: '*My mental health, has been greatly improved by me doing spiritual prayer regularly. I do it every night before bed*' (male, 67+, retired spiritualist facilitator).

Note how this could be seen as an overlap between mental and emotional health. 89 (12.2%) of the questionnaire participants reported that spirituality did not affect their emotional health and 27 (3.7%) of the participants stated it had a negative effect on their emotional health. In this section, 15 of the questionnaire participants mentioned their difficulty in expressing how spirituality affects their emotional health: *'It is hard to express exactly why it has such a positive effect, but it does.'* In relation to being detrimental to health, one questionnaire participant reported: *'I feel other people's worries*'. Another questionnaire participant commented: *'My emotions are not affected by things like that… by my spiritual belief.'* This aspect was not commented upon in the interviews.

<u>Joy of life</u>

The category 'joy of life' was recorded as having one of the highest positive relationships between spirituality and health (n=614; 83.6%). Several of the answers identified that this was due to the fact that spirituality made the participants feel happier. Over a hundred positive qualitative questionnaire answers stated: '*Happy, joyful and thankful'* and another questionnaire participant commented: '*happy, joyful, stress-free and present.*' The notion of 'happiness' was consistently repeated throughout the responses.

The importance of 'joy of life' was expanded upon in the interviews. Personal spiritual beliefs enhanced participants' lives by making them feel happy and purposeful:

'I enjoy myself, you know… not all the time but spirituality is not like... the thing is this is what we have been told, and a lot of people and that's why they reject spirituality, because it stops them from doing the things you want to do, no! It encourages the things you want to do, even better, it allows you to enjoy every moment of it, that's the reason for being spiritual.' (Interview participant 18, male, aged 35, interior designer).

Interview participant 21 claimed: '*my spirituality has massively enhanced my life. It has given me a whole new sense of purpose.'* (female, aged 50, Student).

Only 13.9% (n=102) of the questionnaire participants thought spirituality had no effect at all, and 3.7% (n=18) stated it had a negative effect. None of the questionnaire or interview participants commented on why they reported it to have a null or negative effect.

Mood

A majority (n=594; 81.1%) of the questionnaire participants thought that spirituality positively influenced their mood. The qualitative questionnaire data reported this was due to their spiritual belief having a positive, calming effect on them: '*It helps calm me down to think positively about the situation'.* Another participant commented: *'spirituality calms me and brings me the joy which in turn brings happiness'*.

Some interviewees indicated that spirituality had a positive effect on their mood due to it being a coping mechanism. They perceived that their spiritual belief helped to: *'calm me down'* (Interview participant 15, male, aged 55, support worker) or *'put life into perspective'* (Interview participant 23, female, aged 29*,* Tai chi practitioner).

14.5% (n=106) identified spirituality to have no effect on the participants' mood, and 4.4% (n=32) had a negative effect. A few of the interview participants also discussed how spirituality was perceived to have a negative effect on their mood. For some interviewees, it was a mix of both positive and negative effects, depending on how they were feeling at a specific time:

'When I start chanting, it really does lift my mood in a more consistent way that like... When you do your regular spiritual practice... I think you kind of build a little bubble of contentment about yourself because then when other things happen to you, you just deal with it. Your mood is just stable, and you're grand, and you're fine, and you're kind of like everything is ok, even if this unexpected thing

is happening, you're like ok it's a bit crap I wasn't expecting it, but it'll all work out!' (Interview participant 11, female, aged 35, traveller).

Another interview participant commented:

'*Spirituality can be a good treatment for poor emotional and mental health. Certainly, drugs and surgery can palliate (and most of us need that sort of help at some point), but they cannot cure. I believe that this is one of the major failings of conventional medicine today; it is too often merely papering over the cracks whilst leaving the root cause untouched. That is why, I think, that so many people turn to alternative/complementary medicine for treatment.'* (Interview participant 9, male, aged 61, homoeopath).

These responses highlight how spiritual 'beliefs' have been reported to have both a positive and negative effect on a person's mood, which was part of their personal growth for some. For others, it provided the emotional support a person needs. It is important to note that interview participant 9's profession as a homoeopath may be pertinent in that it might be beneficial to him to promote the health benefits of spirituality.

Self-esteem

Three quarters (n=552; 75.4%) of the questionnaire participants reported that their spiritual 'beliefs' positively influenced their self-esteem. Both the questionnaire and interview participants noted that this appeared to be due to people feeling inner peace and more confidence: *'it makes me feel happy, centred and more self-confident.'* To further support this, another questionnaire participant commented: '*Due to my spiritual beliefs, I feel more confident and at peace with myself.'* This feeling of being *'*centred*'* can be vital to health, as the loss of meaning can impact an individual's resilience and ability to cope with life's difficulties.

Some of the interview participants further expanded on this. Spiritual beliefs were reported to be a 'buffer' against the feeling of depression and anxiety:

'Yeah, the wellbeing thing is kind of more a kind of a peace in yourself a kind of happiness and contentment, and it makes a huge difference, because like I mentioned when I first started, I was feeling kind of down, I was probably entering a depression – I don't like saying I was depressed because I didn't really get a full diagnosis at the time and I don't want to kind of belittle people who really do suffer from clinical depression, but at the same time I think I was going in that direction, I wasn't in a good state, and since I started chanting the attitude toward my brother changed, which immediately brought me up and just my mood just changes – you know I'm human!' (Interview participant 11, female, aged 29, Traveller).

This demonstrates that spirituality may play a central role in reconstructing a sense of 'self' and recovery. Nevertheless, expressions and experiences of spirituality may become part of the problem as well as part of the recovery, in relation to self-esteem. Some individuals are helped by their spiritual community, uplifted by spiritual activities, comforted, and strengthened by their beliefs. However, this study`s data also indicated that others might be rejected by their spiritual community, burdened by spiritual activities, disappointed, and demoralised by their beliefs. Interview participant 15 discusses feeling disconnected from others:

'I feel like I have grown apart from others due to my thinking more deeply about life.' (male, aged 55, support worker).

However, this lack of 'connection' is not necessarily negative, as perhaps the interviewee could be developing a compassionate detachment from others (this could also be seen as an overlap with social health). Some of the interviews suggested that spirituality had a positive influence on participants' self-esteem by helping build up confidence, overall self-acceptance, and self-worth:

'Helping others makes you feel good, and I don't think you should not do that. But my piece of advice would be making sure you have time for you and your spiritual needs because that will make you better at being able to help other people as well building your own feeling of self-worth and self-esteem and I would say making time for yourself' (Interview participant 17, female, aged 32, lecturer).

147 (20.1%) of the questionnaire participants reported that spirituality did not affect a person's self-esteem, and 33 (4.5%) of the participants stated it negatively affected a person's self-esteem. None of the questionnaire or interview participants commented on why they reported it to have a null or negative effect.

Summary

Many questionnaire and interview participants reported that spirituality was an essential factor in their emotional health. This was mainly because it made them feel happy, influenced self-esteem and self-worth, and improved general mood and the joy of life. For some, it was reported that the everyday sense of belonging gave them meaning. Overall, only a small percentage thought it had no effect, and even fewer thought it was detrimental to their emotional health. At times, spirituality was reported to be detrimental to some people's health when it caused increasing anxiety, overthinking, and worrying. For others, it was discussed that having a spiritual belief provided a 'buffer' as it helped change a person's 'attitude' and mindset; they were also able to accept and be at peace with who they are. Spirituality was seen as a way to reduce stress, a defence against depression, as well as helping people deal with anxiety and serve as a coping strategy. Spirituality was perceived as providing some

participants with a sense of belonging and purpose. It was also part of their self-development for other participants, although some felt that they had to go through difficult situations for this to happen. As illustrated, there was also some overlap between mental and emotional dimensions of health.

4.8.4 Social health dimension

Social health is 'the ability to make and maintain healthy relationships' (Scriven, 2017, p.8). With regards to the relationship between social health and spirituality, as shown in Table 28, the mean score was 3.9, not as high as the other dimensions of health, but still showing an effect. The findings from the qualitative answers reported that spirituality had both a positive and negative effect on social health as it assisted some participants in having a 'connection' with others and a shared interest. However, for some of the questionnaire participants, it had a negative effect as they seemed to believe that spirituality made them less sociable and less willing to engage with others, in ways that were detrimental to their own personal health. Social health had one of the highest percentages of no effect at all (n=243; 34%) (in Table 32) in comparison to the other dimensions of health.

Table 32: The reported effect of spirituality on social health

Social health	It has a strong negative effect n(%)	It has a somewhat negative effect n(%)	It has no effect at all n(%)	It has a somewhat positive effect n(%)	It has a strong positive effect n(%)	Overall Mean (SD)
My social health n=727	6 (0.8)	25 (3.4)	227 (31.2)	259 (35.6)	210 (28.9)	3.9 (0.9)
My relationship with my family n=731	6 (0.8)	33 (4.5)	226 (30.9)	246 (33.7)	220 (30.1)	3.9 (0.92)
My relationship with my partner (if applicable) n=657	10 (1.5)	21 (3.2)	234 (35.6)	185 (28.2)	207 (31.5)	3.9 (0.96)
My ability to make friendships n=730	4 (0.5)	22 (3)	264 (36.2)	238 (32.6)	202 (27.7)	3.8 (0.89)
Maintaining friendships n=732	3 (0.4)	28 (3.8)	264 (36.1)	239 (23.7)	198 (27)	3.8 (0.89)

Missing data: 27 (4%) between 102 (13%)

Social health

Table 32 shows that all the overall mean scores were over the midpoint of having an effect. 64.5% (n=469) of the questionnaire participants identified that spirituality positively influenced their social health. Some of the qualitative questionnaire answers suggested this was because spirituality 'connected' them with others: '*It makes me think more about my connections with people. Makes me want to make a positive impact on the world'.* Another questionnaire participant commented: '*It gives*

you emotional strength and self-esteem to have the confidence to meet new people.' This could also be perceived as emotional health by the 'emotional strength' element of this comment.

31.2% (n=227) of the questionnaire participants indicated it had no effect, and 4.2% (n=31) thought spirituality had a detrimental effect on social health. Within the interviews, 20 participants reported spirituality as being both good and bad for people's social health. This was due to the interviewees reflecting on their own 'self': some reported that they viewed other people as not always kind, and others chose to disengage from peer pressure:

'Yeah, I suppose it does make me engage with more like-minded people, but you also go through periods of being unsociable…cause it's like 'Christ!' People are so horrible!' (Interview participant 24, female, aged 35, unemployed).

Interview participant 19 also commented:

'Er, that's a tricky one, I'm a fairly social animal, but it's tricky in that, it's harder I think to talk superficial/spiritual stuff, so really what's going on in the world of celebrities and even sport and stuff, it just passes us by. I`m interested in my own self-development' (female, aged 62, shamanic teacher).

This further demonstrates and expands on how some of the interviewees feel conflicted about how spirituality affects their social health; there is a conflict between the 'connection' with others and looking after the 'self', perhaps because differing views in spirituality restrict some connection engagement with other people.

For many of the interviewees, the results indicate that the notion of 'connection' was a primary reason why they felt spirituality positively affected social health. This was reflected in comments such as: '*I feel connected to all the things: other people, animals, the trees'* (Interview participant 7, male, aged 57, spiritual leader) and '*being social creatures'* (Interview participant 18, male, aged 35, interior designer). This highlights the importance that some participants placed on engaging and connecting with other people.

One of the reasons why spirituality was considered as having a negative effect on social health, was perhaps due to the fact of: *'not needing to feel sociable'* (Interview participant 4, female, aged 40, unemployed) and '*being on my own is ok'* (Interview participant 23, female, aged 29*,* Tai chi practitioner). This demonstrates a personal conflict for some people, for example, wanting to feel belonging and being at peace with themselves, but at the same time also feeling the need to engage and interact with others.

10 of the questionnaire participants referred to the spiritual principle of cause and effect. Some of their comments were: *'believing that a good deed pays off inspires me to help others in my circle and in the community.'* Another questionnaire participant observed: *'I am balanced, a strong belief in karma, I will put the wellbeing of others as a priority, caring and able to make friends/socialise easily [SIC].'*

There is an interesting connection between being sociable and what a participant thinks they might receive a spiritual reward for doing; thus, perhaps implying that they are being sociable because spirituality helps a person become a good person. This was not explicitly discussed in the interview data.

Relationship with family

266 (63.8%) of the questionnaire participants reported that spirituality positively influenced their relationship with their families. Several positive questionnaire answers proposed that their spirituality affected their relationship with their family and friends because it brought them closer together: *'Having a good base of friends and family. For me, keeping in contact is fairly important ... as it is always good to learn from others by discussing and interacting with other people's views.'* 226 (30.9%) of the questionnaire participants reported that spirituality had no effect on their relationship with their family, and 39 (5.3%) of the participants stated it had a negative effect on their relationship with their family. None of the questionnaire or interview participants commented on why spirituality might have no or a negative effect.

Relationship with partner

Over half (n=392; 59.7%) of the questionnaire participants indicated that spirituality positively influenced their relationship with their partner, because it helps them better relate and communicate with each other. This was further expanded upon in the qualitative data, as one questionnaire participant commented: *'Due to my spiritual beliefs, I have a much better relationship with my wife and family.'* Another mentioned: *'Our joint spiritual growth has brought my wife and me much closer together. We engage in doing spiritual things together.'*

As regards a relationship with a partner, a higher percentage, in comparison (n=234; 35.6%) to the other dimensions of health, stated spirituality had no effect, and 31 (4.7%) reported spirituality had a negative effect on their relationship with their partner. More people skipped this question than the rest of the health and spirituality questions, possibly due to the participants not having partners, but no data was collected to confirm this.

Several of the interviewees' answers suggested that their spiritual beliefs made them feel more 'connected' with their partners, due to engaging in the same activities and having shared beliefs: *'My partner and I meditate together. Which I feel, brings us closer together.'* (Interview participant 8, female, aged 31, lecturer). Interview participant 1 also commented: '*My wife and I are both involved with the church, which means we have similar interests and can talk about what's happening.'* (male, 67+, retired spiritualist facilitator).

This would indicate that spirituality has the potential to bring some couples closer together due to the sharing of the same interests and practices. They belong to the same community as others who share values and offer mutual support.

Making friendships

A large number (n=440; 60.3%) of the questionnaire participants believed that spirituality positively affected their ability to form friendships. The remarks suggested this was because their spirituality facilitated them in making friends, for instance, by going out walking or regularly seeing other community members. A typical positive answer in the questionnaire data was: *'connecting with people'* or *'engaging with like-minded people and being more generally sociable'*. Thus, some participants reported that spirituality gave them a way to 'connect' to other people. This was also reflected in interview participant 13 answer:

'Some of my friends are very spiritual. I think that being spiritual in the way that I've described it has made me more open to interacting with people because really, I developed that kind of philosophy and my interest between groups when I did my Master's, and that was like the only guy from the UK in a group of internationals, and it was just fantastic like learning about everyone and all their cultural traits, and I've had some of the most wonderful interactions. Like with people from completely different backgrounds. So, I guess that I would say that spirituality has influenced me and the way I engage with people' (male, aged 28, researcher).

Interview participant 18 further supported this by saying:

'I've got friends who believe in different things and do different things, and this is the beauty of living, and this is the beauty of being able to have the awareness, you can enjoy your life. I feel very connected to them, even when they are far away' (male, aged 35, interior designer).

Some questionnaire participants identified that spirituality helps them be more 'confident and happy to engage with others' when interacting with other people. One questionnaire participant stated:

'Being more spiritual, aware of others leads you not to judge others as quickly. If a snap judgement is made, you are able to realise that it may be because of stereotypes displayed in media and rethink your judgement with a more open-minded and understanding approach'.

This comment highlights how spirituality enabled participants to have the opportunity to reflect, thus linking to the 'self' and 'connection' theme of spirituality.

36.2% of the questionnaire participants stated it had no effect. This was one of the highest areas of no effect at all. A small minority (n=26; 3.5%) of the questionnaire participants expressed that spirituality had a negative effect on making friends. Some of the questionnaire participants also commented that spirituality had a negative effect on their social health, as they are now 'pickier' over choosing friends; this could be due to looking after the self: '*I feel more disconnected from people and normal life because I am not like them anymore. I am more aware and observant than many people'*. Another questionnaire participant commented: '*I am now more picky over who I engage with and cannot be bothered with small talk*.'

<u>Maintaining friendships</u>

This section consisted of the same themes of spirituality as the 'making friendships' section. Half (n=491; 50.7%) of the questionnaire participants acknowledged that spirituality positively influenced 'maintaining friendships.' Some of the positive written answers suggested spirituality was holding a similar belief: *'Improved long-term relationships with the people and a better understanding of people and what they do and why they do it*.' One questionnaire participant commented: *'having faith in myself has been so good for me to support this further. But also, being drawn to others as we have shared beliefs.'* Therefore, sharing the same spiritual beliefs and practices was reported to help some people maintain friendships.

On the other hand, 264 (36.1%) of the questionnaire participants stated spirituality had no effect, and 31 (4.2%) stated it had a negative effect on maintaining friendships. It should also be noted that there was a 10% decrease between making friendships in comparison to maintaining friends. This was not commented upon in the questionnaire qualitative data. This may indicate that the questionnaire participants were potentially better at making new friends, rather than maintaining long term friendships. This was not commented upon in the interviews. However, it needs to be acknowledged that this was just one point in the study, and the mean score for both quantitative data was the same.

<u>Summary</u>

The findings for social health were more mixed (in regards to having less of a reported effect) in comparison to other dimensions of health. However, there were a significant number of positive

responses regarding the relationship between social health and spirituality. The results in this section showed that, for some, holding a spiritual belief boosted their self-esteem; spirituality gave them the confidence to meet new people, making more like-minded friends, as well as providing them with a sense of belonging. For others, it made their 'connection' with their families and partners stronger, due to similar interests. For some participants, spirituality was thought to protect people from social isolation and promote healthy family relationships and broader social networks. Spirituality was also reported to provide individuals with a sense of belonging and self-esteem (self-esteem was also noted in emotional health) by offering spiritual support in times of adversity. However, at the same time, other participants felt that spirituality had a negative effect, because it made them feel disconnected. It was also shown to make some people feel less sociable. Finally, a quarter of the participants reported spirituality had no effect on social health, whereas only a few stated spirituality had a detrimental impact on their health.

4.8.5 Societal health dimension

Societal health is defined as 'how well a society offers every person an equal chance to gain access to the goods and services vital to being able to function as a member of a given society, such as making sure everybody has equal opportunities, fair politics and all have access' (Scriven, 2017, p.8). As shown in Table 28, the overall mean score for this dimension was 3.9, indicating that spirituality had a more positive than a negative perceived effect on societal health. One of the reasons why the qualitative answers suggested it was positive was because the participants reported that they had been able to think in more depth, and they did not need to rely on others so much or need to have negative people in their lives. Table 33 shows that over a third (n=250; 34.2%) of the participants said spirituality did not affect their societal health. Twenty of the questionnaire participants explicitly stated that spirituality did not affect their societal health in the comment box.

Table 33: The reported effect of spirituality on societal health

Societal health	It has a strong negative effect n(%)	It has a somewhat negative effect n(%)	It has no effect at all n(%)	It has a somewhat positive effect n(%)	It has a strong positive effect n(%)	Overall Mean (SD)
My community participation n=732	5 (0.7)	28 (3.8)	277 (37.8)	237 (32.4)	185 (25.3)	3.8 (0.89)
My safety n=730	2 (0.3)	20 (2.7)	278 (38.1)	207 (28.4)	223 (30.5)	3.9 (0.9)
My sense of belonging n=730	5 (0.7)	20 (2.7)	196 (26.8)	226 (31)	283 (38.8)	4.1 (0.91)

Missing data: 24 (4%) between 29 (4%)

Community participation

Table 33 shows that over half (n=422; 57.7%) of the questionnaire participants reported that spirituality positively influenced their involvement in the community. The findings indicate that 'connection' and having a 'sense of belonging' played a critical part here, as several of the positive questionnaire answers expressed: *'I engage more with people in the community and thus make more friends*.' Another questionnaire participant commented: *'I love being with people now! I feel a sense of belonging'*. This demonstrates that shared spiritual beliefs helped create connections. However, some of the negative answers also suggested that spirituality was detrimental to health, as one

participant stated: *'I now don`t engage with unkind people and I have less patience with others.'* This will be discussed in more detail below.

A small number of (n=32; 4.4%) the questionnaire participants referred to spirituality as being a means to build communities:

'I don't feel comfortable discussing spirituality with friends as unfortunately, people do not seem interested in discussing spiritual issues in a social setting. However, in the spiritual community, I do feel that spirituality is significant in community building—but it should be inclusive and non-denominational, as people of all faiths can come together comfortably.'

This indicates that some people who identify as SBNR consider spirituality an essential part of a healthy society and a means of bringing people together. This was further supported by eight of the interview participants, who reported that spirituality was an essential aspect of the community as there was a need to feel connected to others, and/or be part of the '*bigger picture'* (Interview participant 3, male, 45, life coach). Part of human nature is to socialise with other members of the community; some of the interviewees discussed this as belonging to small communities:

'I've been to some slimming groups and stuff before. They were quite good. I would go to this thing called the Sunday assembly, which is a church of no religion in a way, and it's getting together with other people and learning about different things and singing. It's once a month and my daughter really likes singing, I try, and the people there are really nice like they just want to be a part of a community, and there isn't really community anymore.' (Interview participant 20, female, aged 50, student).

Comments from participants illustrated the feeling of being part of a small community due to having a shared interest, but at the same time, for some, this could lead to a potential disconnect with broader society.

Another aspect the interviewees expanded on was the notion of relating to others in the community; they wanted to be part of the community, but they felt disconnected, perhaps even isolated. Three interviewees (3, 4, 5) identified the need to be part of larger communities. To illustrate this, interview participant 4 stated:

'I feel like I contribute to and need to be part of my local communities as I have lots to offer, but equally, I enjoy being with others, even if we are not speaking.' (female, aged 40, unemployed).

Interview participant 5 also gave an example of why this is the case: *'I used to be involved and volunteer in many of the local communities' activities such as Remembrance Day, the local village fate,*

any local festivities but this used to drain a lot of my energy but then I reflected and thought about my needs more and question what am I getting from this? So, I stopped offering to help and not spread myself so thin. And look after myself more… you cannot drink from an empty cup!' (female, aged 55, homoeopath).

More than a third (n=277; 37.8%) of participants claimed that spirituality had no effect, and 33 (4.5%) acknowledged that it had a negative impact on their participation in the community. Another questionnaire participant indicated a negative impact of spirituality in both the quantitative and qualitative data, due to feeling comfortable with their beliefs and also not needing others to affirm their feelings: *'I do not feel the need to engage with people in my community as much as I do not feel I have a lot in common with them, but I also feel complete because of my spirituality.'*

Safety

Over half (n=440; 58.9%) of the questionnaire participants thought their spirituality positively influenced their safety, yet none of them discussed this in the relevant qualitative data. 38.1% (n=278) of the questionnaire participants claimed it had no effect, which was a higher percentage than in the rest of the questions; 3% (n=22) of the participants thought it had a negative effect. Even in the interviews, only one person (Interview participant 5) commented on personal safety. This specific participant identified feeling safe in many ways, such as safe in her 'beliefs' or feeling free from fear:

'Being safe for me (pause) growing up, I would be going to confession and confess your sins. And you know if you didn't, if you forgot something, I remember being young and coming out and thinking oh I forgot to tell him such and such. But obviously, I don't go to confession now so, but that was kind of safe, and it was kind of driven by fear' (female, aged 55, homoeopath).

Sense of belonging

A majority (n=509; 69.8%) of the questionnaire participants perceived that spirituality positively affected their sense of belonging. Several of the answers suggested this could be due to them holding a 'belief' which gave them a 'feeling of purpose' and 'meaning in life': '*due to my beliefs my confidence has increased which makes it easier to engage.'*

For all the interviewees, a sense of purpose and belonging appeared to be strong themes in relation to the spiritual activities they engaged with, or in relation to feeling a 'connection' with a selective group. For example: *'belonging to a spiritual church'* (Interview participant 1, male, aged 67, retired spiritualist facilitator); *'A sense of belonging within the community'* (Interview participant 3, male, 45, life coach) or '*belonging to a yoga group'* (Interview participant 17, female, aged 32, lecturer).

Just over a quarter (n=196; 26.8%) of the participants stated that spirituality had no effect, and 25 (3.4%) stated it had a negative effect on their sense of belonging. One qualitative questionnaire participant commented: '*I feel more disconnected from people and normal life because I am not like them anymore. I am more aware and observant than many people I know. I don't worry about normal mundane things like wealth, cars, appearances.'* Another commented: *I feel more confident in my own beliefs, which not only gives me a sense of belonging but less of a need to belong with others or in society.*

Summary

The relationship between spirituality and societal health was reported to have both positive and negative effects, although the mean score was quite positive overall. The themes of spirituality that seemed to have the most prominent relationship to health were connection, sense of belonging (values), and belief. Some participants discussed that they felt confident and happy to engage with others. For others, they reported not needing to engage with people in their community. Some participants suggested this was because of their spiritual beliefs: they had time to reflect on their relationships with others. They realised that other people were not very helpful to their health. The notion of building communities and building self-esteem was also discussed.

There was a lack of clarity in some of the responses as to the distinction between social and societal health. Not feeling part of a community was described as harmful to some people's health, as they felt isolated. Spiritual beliefs made them feel more psychologically secure, so they felt safer. Most of the interviewees talked about feeling a sense of purpose and belonging. There seemed to be a strong relationship between the spiritual activities they engaged with, or simply a feeling of spiritual connection to others in the world. Finally, the notion of fear was also discussed, but the type of fear being discussed seemed to be belief in doing something wrong, not a spiritual fear. There was some overlap between social and societal health in both the interview and questionnaire data, which might have been due to the participants having difficulty understanding the concepts.

A reported relationship between spirituality and societal health, compared to other health dimensions, remained high in the quantitative data (3.9), though in the qualitative data, there was less of a reported relationship. Although it was still high in the quantitative data (the overall mean score was 3.9), with the qualitative data, some participants thought it had no effect, and a few believed it was harmful to their health. However, the importance of being part of a community figured prominently in both data sets. The data further revealed that there was not a strong reported link between spirituality and safety, yet a few participants felt safer because they considered themselves part of the wider community. Conversely, possessing a sense of belonging was rated highly in both

data sets. These findings suggest that this feeling amongst participants was due to spirituality giving individuals a sense of 'being on a path,' which equipped them with a feeling of belonging, purpose and direction, as well as being part of life's plan or something bigger than themselves.

4.8.6 Spiritual health dimension

Scriven (2017, p.8) states that, for some people, spiritual health relates to 'religious beliefs and practices; for other people, it is to do with personal creeds, principles of behaviour and a way of achieving peace of mind and being at peace with oneself'. The overall spiritual mean score was 4.2 (Table 28). Table 34 shows that over two thirds (n=535; 70%) of the questionnaire participants remarked that there was a positive relationship between spiritual health and spirituality. Almost a quarter (n=179; 23%) of the questionnaire participants said that spirituality had no effect on their spiritual health. Only a small proportion (n=7; 7%) of the participants stated that it had a negative effect on their spiritual health. There were no negative written answers in the qualitative questionnaire data within this section, and those participants who said it did not have any effect did not comment on why. All the interviewees identified a strong positive relationship between spirituality and spiritual health.

Table 34: The reported effect of spirituality on spiritual health

Spiritual health	It has a strong negative effect	It has a somewhat negative effect	It has no effect at all	It has a somewhat positive effect	It has a strong positive effect	Overall Mean (SD)
	n(%)	n(%)	n(%)	n(%)	n(%)	
My spiritual health n=728	5 (0.7)	4 (0.5)	160 (22)	198 (27.2)	361 (42.7)	4.2 (0.86)
Engagement with spiritual activities n=726	9 (1.2)	19 (2.6)	200 (27.5)	213 (29.3)	285 (39.3)	4 (0.94)
How often I engage with spiritual activities n=725	11 (1.5)	16 (2.2)	272 (37.5)	189 (26.1)	237 (32.7)	3.9 (0.95)
Feeling connected with something bigger than the world n=730	7 (1)	9 (1.2)	152 (20.8)	186 (25.5)	376 (51.5)	4.3 (0.89)
My feeling of being at peace n=732	8 (1.1)	9 (1.2)	113 (15.4)	197 (26.9)	405 (55.3)	4.4 (0.86)

Missing data: 27 (4%) between 34 (5%)

Spiritual health

Table 34 demonstrates that there was a reported positive effect between spiritual health and spirituality. All the mean scores in this section were similar, apart from '*how often I engage with spiritual activities;'* as this was only slightly lower than the rest. The majority (n=559; 69.9%) of the questionnaire participants thought that their spirituality positively influenced their own spiritual

health. In the qualitative data, the questionnaire participants' answers suggested this was because they felt a greater sense of belonging and connection: *'A sense of belonging, connection and awareness.'* To further support this, another questionnaire participant commented: *'Having a connection with something makes me feel a sense of belonging and purpose.'*

The notions of 'connection' and 'sense of belonging' were further echoed in the interview answers. Interview participant 3 stated: '*My spirituality makes me feel very connected, happy, aware, which is so beneficial for my spiritual health because I feel regularly cleansed and in control of my life'* (male, aged 45, life coach).

Interview participant 1 also echoed this by saying: '*My belief affects my spiritual health in many ways as it helped me to find my own sense of meaning, purpose and positive connection with others'* (male, 67, retired spiritualist facilitator).

160 (22%) of the questionnaire participants reported that spirituality had no effect on their spiritual health, and 9 (1.2%) of the participants stated it had a negative effect on their spiritual health.

Engagement in spiritual activities

Just under half (n=498; 47%) of the questionnaire participants believed that their personal spiritual beliefs positively affected how often they engaged with spiritual activities. This might be linked to the fact that only 50% (presented in section 4.7) of the participants engaged in spiritual practices. Those who provided written answers in the questionnaire suggested that their spiritual practices made them feel happy, grounded and connected: *'Particularly when I do my favourite hobby yoga, I have time to reflect. It reminds me that I am loved by all and supported prayerfully by the community and the rest of my family'* (female, aged 40, unemployed).

Similarly, another questionnaire participant commented*: When I do yoga or walk in the park, I feel more of a connection to the world and others and to nature'.* For these participants, feeling more 'connected' and engaging with green spaces were reported as being essential to their happiness and connection with others.

This was further expanded upon in the interviews, as several of the interviewees discussed at length how necessary their own experiences/expressions of spirituality were to their own spiritual health:

'I am really interested in spirituality and people's health and wellbeing. I practice yoga and mindfulness every day, which makes me happy and its good for my own spiritual health. I am 61 years old. I am now a Homoeopath and teach mindfulness and meditation. When I was 12, partly because

I was shy and bullied at school, I thought yoga would be the way to help me overcome it. Then as I got a bit older, I turned to 'mindfulness' at about 16-17, to help me with stress and anxiety.' (Interview participant 9, male, aged 61, homoeopath).

Interview participant 14 also described: *'It has made it better, it gives me a faith, it gives me a purpose, it gives me some peace and tranquillity, and I think if you believe, ok the ego is very very complex, I believe that spirituality, quietens the ego, makes it less prevalent, gives you an interest and an understanding in the wider picture of the world, and I believe that I hadn't been looking after myself spiritually, and that actually helped for psychosis to sort of take plant.'* (Female, aged 55, Spiritual Healer).

A consistent finding in both the questionnaire and interview data was how spirituality and spiritual practices 'connect' people together, making people feel grounded and providing a way of coping with daily life stresses, as well as traumatic events in their lives. The points expressed by all these participants suggest that their spiritual beliefs and practices helped their health because they gave them the means to deal with stress and anxiety. A secondary reported benefit could be that the enjoyment of an activity, such as meditation and yoga, can lead to positive spiritual health.

200 (27.5%) of the questionnaire participants indicated that spirituality had no effect on their spiritual health, and 28 (3.8%) of the participants stated it had a negative effect on their spiritual health. This was not commented on in the qualitative data.

Feeling connected

A majority (n=562; 77%) of the questionnaire participants identified that spirituality positively influenced 'feeling connected with something bigger than the world'. The questionnaire participants indicated this was due to having a connection with and awareness of a higher power:

'Having a connection with something almost 'supernatural' helps me believe that there is much more to learn about the earth, universe and its inhabitants, it also gives you a humbling sense of mortality.'

Another questionnaire participant discussed:

'The universe has helped me connect to other people in a way so that I feel the presence of them at any time. It's as though they're in my heart and understand me better than myself or anyone. I feel that my beliefs help me be my natural self to enjoy it and feel loved by the universe and people.'

These quotes illustrate the need for some people to feel 'connected' and that holding a spiritual 'belief' might be a means to accomplish this. For some questionnaire participants, their spiritual 'belief' brought them closer together with others. This was discussed further by interview participant 8, who said: *'The universe has infinite energy and its own consciousness as well, I believe, so it's like being part of a big thing like we're all connected'* (female, aged 31, lecturer).

Interview participant 2 also talked about feeling connected with a higher power: '*For me, a 'higher power' gives me a great sense of optimism, hope, a sense of purpose… like my life is in control... everything happens for a reason.'* (male, aged 55, spiritualist leader).

As a result, people's spiritual beliefs and practices were reported to provide a sense of connection, make them feel grounded, and help them cope with living. A constant in the questionnaires and interview findings was that having a 'connection' with something almost 'supernatural' is essential and gives some people a humbling sense of their own mortality.

152 (20.8%) of the questionnaire participants reported that spirituality had no effect on feeling connected, and 28 (3.8%) of the participants stated it had a negative effect on feeling connected with others. This was not commented on in the qualitative data.

<u>Being at peace</u>

A large proportion (n=602; 82.2%) of the questionnaire participants reported that spirituality helped them to achieve a 'feeling of being at peace'. The questionnaire participants discussed different types of peace, such as feeling at peace with oneself and finding peace in calm environments during stressful times. Responses from the questionnaire participants included: *'I feel calm and at peace with the world'; 'I engaged with all that is part of creation, so finding peace in nature in particular' and 'Just my general peace and how content I am.'* (Interview participant 4, female, aged 40, unemployed).

Another point that was raised in this section was that a clear majority of the questionnaire participants stated that spirituality had a strong positive effect on their feelings of being at peace, as it helped them to understand how they 'fit' and 'belong' in this world.

This can be related to the participants' deeper spiritual awareness and perceived sense of belonging. To demonstrate this point, interview participant 7 remarked:

'I just had this moment of going from total despair to total peace. Where I just felt a sense of divine love. I mean, I have words for it now, but I did not have words for it then. It was just this

wonderful feeling of goodness and of being cared for surrounded by love, and it was a wonderful experience.' (male, aged 57, spiritualist leader).

This was further discussed by interview participant 14, who commented: *'Interestingly I know in that group one or two people who have been affected with physical difficulties or disabilities. But their spiritual awareness rather than psychic awareness. But the relationship between the two is interesting because the word 'psyche' is the Greek word we translate as 'soul'. But psychic in the sense that it has been degraded*' (Female, aged 55, Spiritual Healer).

For some participants, spirituality was reported as a sense of belonging with themselves, with others, and within the world. For others, it was holding a belief that enabled them to feel like everything would be ok; this influenced their health because they felt more at peace with themselves. They could accept themselves and others for who they were, thus improving self-esteem and self-worth. This also involved finding peace in stressful situations or being at peace in specific environments. This in turn was reported to provide some participants with optimism and a coping strategy when they find life difficult.

113 (15.4%) of the questionnaire participants reported that spirituality had no effect on being at peace, and 17 (2.3%) of the participants stated it had a negative effect on being at peace. This was not commented on in the qualitative data in both data sets.

Summary

The questionnaire results revealed a positive relationship between spiritual beliefs and spiritual health, with the participants identifying spirituality and spiritual belief as part of their core being and lifestyle. These findings demonstrate that spirituality was reported to positively impact health by helping people feel a sense of purpose and feel connected with others. In turn, this feeling was revealed to give some participants the resilience to cope with life's everyday stresses. As noted above, engagement in spiritual activities was reported to be essential to some participants but not to others. Indeed, it was vital for some participants as it helped connect people with each other, making them feel grounded whilst further providing a way of coping with daily life stresses and traumatic events in their lives. For other participants, spirituality was a way to cope with stress and anxiety. Critically, a strong theme that flowed through the findings was that of connection; the participants' spirituality made them feel connected with others, and there was therefore a clear sense of purpose due to their feeling of connectedness to something outside of themselves.

The strongest relationship was found between the 'feeling of being at peace' and spirituality. Throughout the data, it was clear that spirituality was perceived by the participants to make them happy, both with themselves and with the world. This also involved finding peace in stressful situations or specific environments. This influenced their health, because some participants felt they could cope with life better and deal with stressful situations more adequately. They could accept themselves and others for who they were. This potentially provided people with optimism and a coping strategy when they found life difficult.

A quarter of the participants thought spirituality had no effect on their spiritual health. Only a small percentage believed spirituality was detrimental to their spiritual health. Most of the participants' spirituality was seen to provide a sense of belonging and awareness, a sense of spiritual growth, engagement with spiritual practices, and a feeling of being at peace. There was a predominant use of the word 'feeling', such as feeling at peace, feeling connected with others and the world. Some people believed spirituality and spiritual practices did not influence their spiritual health. Only a minority thought spirituality was harmful to their spiritual health.

4.8.7 Multifaceted impact of spirituality on all dimensions of health

Many of the questionnaire participants discussed the link between different dimensions of health. Some described how their personal spiritual beliefs made them mentally healthy, which in turn they perceived to have a positive effect on other aspects of their health. To illustrate this, one questionnaire participant commented: '*Part of my spirituality is that I meditate, which is good for all aspects of my health'*. To further support this, another questionnaire participant felt: '*my personal beliefs shape my lifestyle choices, so I eat healthy foods and exercise which is good for my physical health, but it's also good for my mental health.'*

This was also found in the interview data as three of the interviewees (12, 14 and 9) mentioned the interconnected relationship between physical health and mental health. They suggested that if one aspect of their health was poor, it had a detrimental effect on other areas of their health. To illustrate this point, interview participant 12 remarked that:

'Positive mental health helps your physical health, other people I think to look at spirituality and yoga and things like that. A lot of people look at things like this and think that it's kind of an exclusive thing and that it's something that you need money to do, and a lot of people will look at it and shake it off, and they're not getting the benefits from it, and so in that sense, they can affect other

people's health because they don't have this extra element of health to draw upon.' (male, aged 28, department manager).

Interview participant 10 similarly commented:

'It is also partly to do with our own self-image. In a sense, disease occurs when we aren't viewing, and therefore living, life in accordance with our inner truth. This disease, if ignored, eventually manifests as a disease in the physical body. Consequently, most sickness that I have seen in my practice results from an emotional, mental or spiritual derivation. Therefore, a true, lasting cure cannot occur until the causative issues have been addressed and dealt with. I am sure that many illnesses in the mental and emotional area, such as depression, paranoia, etc. are a result of losing our spiritual moorings, our link with God, if you like, and this is often quite easy to see in people' (female, aged 48, Reiki Practitioner).

4.8.8 Summary

The findings of this section demonstrated that the participants reported that spirituality positively influenced different dimensions of health in a wide variety of ways. Overall, within the quantitative data, spirituality was reported to have a positive impact on all dimensions of health. In the quantitative results, spirituality was seen as having the most significant effect on mental, emotional and spiritual dimensions of health. In comparison, there was less evidence of a perceived effect of spirituality on physical, social, and societal health (although it was still high in some areas). Some of the participants (both questionnaire and interview) reported that spirituality motivated them, enabling them to cope with life, connect with others, and facilitate ethical choices. Furthermore, spirituality was also reported to indirectly affect different dimensions of people's health, due to the secondary effects of engaging with others, improved communication, and a motivation to stay healthy.

In the case of physical health, the quantitative results showed a generally positive relationship. Spirituality improved physical health as participants felt encouraged to make moral and ethical choices, and participants felt motivated. Moreover, the participants' comments indicated that spirituality is perceived as improving the overall physical health of specific individuals. Some participants saw spirituality as a route to more fitness and engagement in spiritual practices, better sleep and diet, and motivating healthy behaviour and lifestyle choices. Apart from physical fitness, these findings were also generally supported by quantitative data.

In terms of mental health, the quantitative data presented a strong perceived relationship between spirituality and mental health, with spirituality enabling the participants to look at situations in a positive light. The findings suggest that it was partly due to participants' spiritual beliefs that they

could engage with others within the community. Further to this, the notion of communication with, and understanding of oneself as a person was highlighted in both data sets. The findings also revealed that a few participants thought spirituality had a detrimental effect on their mental health, as they felt disconnected and detached from others.

When it comes to emotional health, the quantitative data showed there was a strong perceived relationship between spirituality and emotional health. The qualitative data further indicated this was due to increased happiness among the participants. In particular, spirituality improved self-esteem, self-worth, improved general mood, and encouraged '*joy of life*'. For some, it was the everyday sense of belonging that gave them meaning, contributing to individual's happiness, and allowing them to enjoy activities that made them feel content and spiritual.

For social health, the quantitative data results were on the whole positive regarding the relationship between spirituality and health. However, they were not as positive as some of the other dimensions of health. In the qualitative findings, spirituality was thought to protect participants from social isolation and to promote healthy family and broader social networks. It also provided individuals with a sense of belonging and self-esteem by offering spiritual support in times of adversity. However, at the same time, a few participants felt that spirituality had a negative effect, making them feel disconnected, without the need to engage with other people to be fulfilled. According to the findings, spirituality was noted to make some participants feel less social; there was a feeling that some people were less trusting of others because of their potential ulterior motives.

Moreover, the quantitative results for societal health were similar to those for social health. For example, some participants discussed how they felt confident and happy to engage with their wider community, whilst some did not feel this need to engage with others. This result was shown to be due to their spiritual beliefs, as they had time to reflect and conclude that contacts with others of different spiritual beliefs were not always beneficial to them.

Spiritual health was discussed in greater depth in the quantitative data. Many of the participants identified spirituality and spiritual belief as a crucial part of their core being, identity and lifestyle. Spirituality was reported to have a positive impact on health, helping some people feel a sense of purpose and connection with others. The findings suggest that this gave some participants the resilience to cope with the everyday stresses of life. Despite this, engagement in spiritual activities was essential to some, but not all. Nevertheless, for the former, spirituality was reported to be vital as it helped to connect people, making participants feel grounded and providing a way of coping with daily life stresses and traumatic events in their lives, providing and strategy in order to cope with stress and anxiety.

Within these health sections, there were overlapping findings. For example, with regard to mental and emotional health, the themes 'anxiety' and 'stress' appeared in both sections. For some of the participants, spirituality was reported to have a positive effect on several dimensions of their health, such as providing a way to deal with stress, motivating them to be healthy, helping them to make positive ethical choices, and assisting them in having a positive effect on others. However, at the same time, one of the less significant themes that arose in this study was that for some participants, spirituality might be harmful to health, as it can make people overthink, which can be a cause of anxiety in some cases.

4.9 Thematic map of the reported relationship between spirituality and health

The results of this study led to the development of a conceptual map, referred to as the 'Spiritual Health Effects Map (SHEM)' (Figure 10). SHEM emerged from the themes identified in the dimensions of health results. The same process encapsulated these themes in Figure 9. The themes emerged when both the questionnaire and qualitative interview data were being analysed. The map developed out of the thematic analysis of the qualitative data; although diagrammatically represented, this is not a cyclical or linear process. The themes of the original spirituality map (Figure 9) presented earlier have now been amalgamated with the health dimensions to illustrate how spirituality relates to health dimensions. Within this map, there are two parts: 1) the themes of spirituality and 2) the health dimensions.

Figure 10: Spiritual Health Effects Map (SHEM)

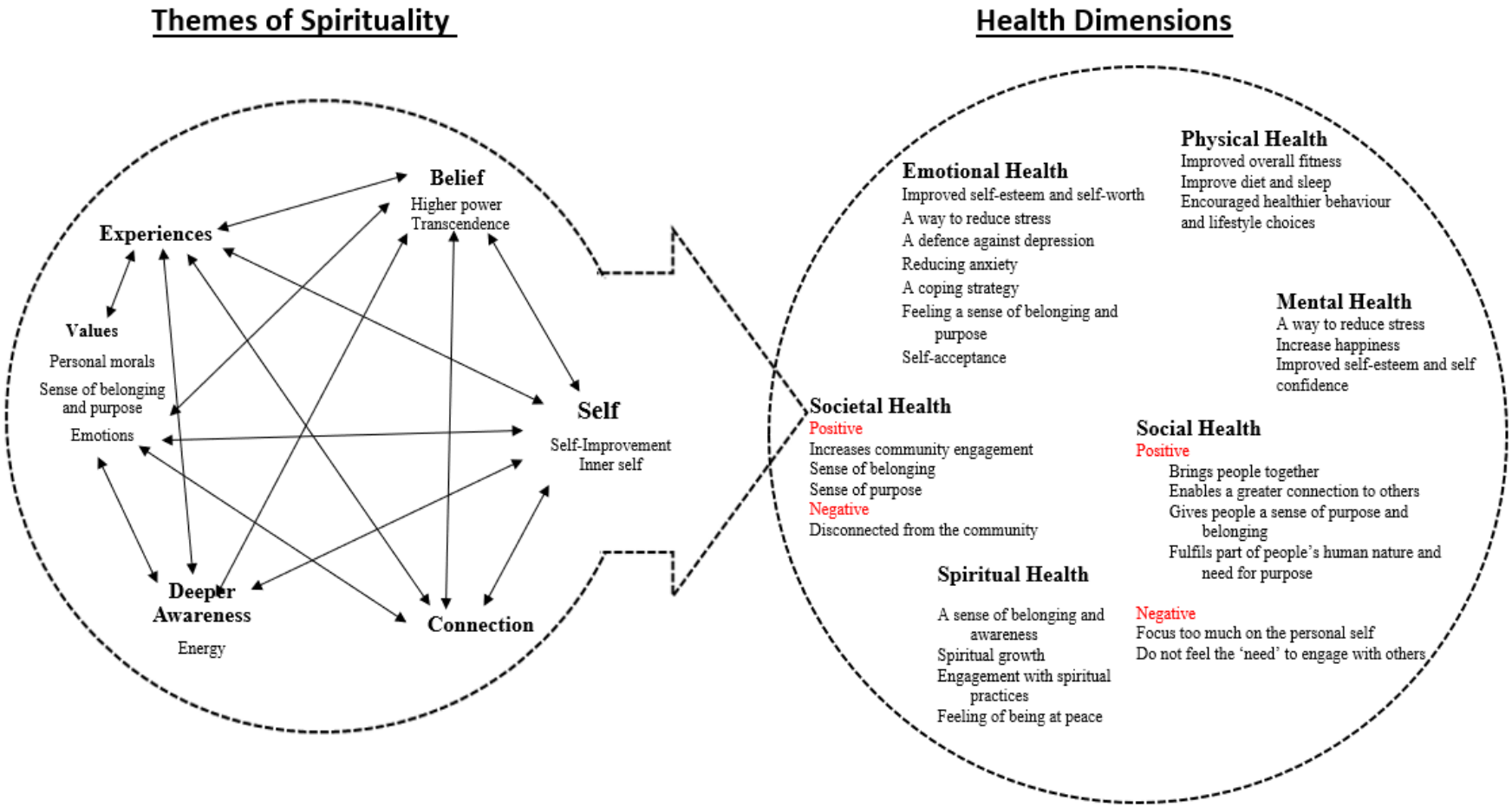


Figure 10 presents the results of how some individuals describe the effects of spirituality on their health dimensions. The 'themes of spirituality' feed into the 'health dimensions'. In the 'themes of spirituality' circle, there are six themes: 'self', 'belief', 'connection', 'values', 'experiences' and 'deeper awareness'. The smaller words under the broader themes are the subthemes. On the right-hand side of the map, in the large circle, are the six dimensions of health. The circle around the themes is represented by dashes and is semi-permeable, to signify the movement in and out of spirituality and health (as also illustrated in Figure 9).

The relationship between spirituality and health does not connect linearly and interlink; this relationship is far more complex, as people are holistic beings. As identified in the results, various themes of spirituality were perceived as impacting different dimensions of the participants' health (as discussed in the various dimensions of health). SHEM was developed for conceptual understanding and is presented simplistically as a tool for clarity and insight. SHEM is not intended to be prescriptive, but offers a conceptual map through which Public Health practitioners may consider some of the ways in which spirituality could potentially influence health and how they can begin to operationalise spirituality (discussed in more depth in the next chapter).

Theme one: connection

One of the main findings of this research was that spirituality enabled people to feel connected. The connections were to '*other people'*, '*communities*', '*living beings such as animals',* '*the environment,'* '*green spaces'* and *'grand buildings'.* For some, '*feeling connected'* to a '*higher power'* allowed them to feel like they were supported when they encountered difficulties in their lives. This sense of connection was perceived to be vital for people's health and social support.

Theme two: self

The thematic analysis of the questionnaire and interview data showed that the participants reported they were strongly inspired to be looked after and improve, develop, and maintain themselves, which influenced their health. The participants demonstrated the notion of looking 'after the self' and developing the 'inner self' by describing behaviours such as: *'eating healthily'*, *'exercising'* and *'not drinking large quantities of alcohol'*. These results suggested that not only was this a crucial part of their spirituality, but it was also fundamental to their health.

Theme three: beliefs

Both the questionnaire and interview data results suggested that, for some people, their spiritual beliefs made them feel more in control of their lives. This was demonstrated in the participants'

answers, for example: *'My beliefs give me a sense of control'* and *'my beliefs enable me to have a sense of hope and purpose'*. This meant that to an extent, they felt that they were able to control what might happen to them, and that they could make healthy or unhealthy lifestyle choices independently based on their own beliefs.

Theme four: values

The data suggested that spirituality was reported to help the participants get in tune with their ethical and moral compass. This enabled participants to decide what they believed to be right or wrong, and how they should behave: '*being kind to others'; 'not harm other people*'. Due to this, some of the participants chose to '*abstain from eating meat and drinking alcohol'* based on moral reasons; this, in turn, was perceived as having a positive effect on their health. Values can be a motivator to help shape people's lives, which in turn can improve their emotional health.

Within the 'values' theme, the results led to the development of a sub-theme 'sense of purpose'; the participants expressed that a sense of 'purpose' was important to their health. These results suggest that having a sense of purpose is a fundamental part of a '*fulfilling life'*, and many of the participants in the study believed spirituality gave them that '*sense of purpose*'.

For most participants in this study, spiritual beliefs and practices made them feel *'happy'* and *'joyful'*. This can be attributed to the 'emotions' subtheme, as it gave them a way to cope with life stresses. Many of the participants referred to a '*sense of happiness',* which was reported to have positively affected health. These emotions were considered motivators and provided a sense of purpose. For some, their spiritual beliefs and practices were essential to who they were as people and formed part of their daily routine.

Theme five: deeper awareness

Although this was a theme of spirituality in the qualitative data from both the questionnaire and interviews, it was not perceived to be directly related to health. Deeper awareness were still included SHEM as it was still considered a theme of spirituality.

Theme six: experiences

This theme was not as strong as the other themes in relation to health; however, it did arise in certain areas, such as in the spiritual health dimension. Participants mentioned the experience of engaging in spiritual activities or with the outside environment. For example, one of the participants stated, *'I LOVE YOGA'* (participant's capitalisation), and another spoke about the experience of using *'green spaces.'* These experiences can be part of spirituality but also separate from it. They can be considered

borderline experiences that exist in multiple forms; this makes it difficult to disentangle the spiritual and non-spiritual experiences.

4.9.1 Issues with SHEM

Potentially there are aspects missing from this map that are difficult to measure or put into words. For example, there is the environment in which people live and where they engage in spiritual practices. The issue is that these factors are too general for people's lives and cannot always necessarily be attributed to spirituality. Some people do not believe spirituality affects their health: this is not incorporated into this model. A person may have unique experiences that are directly related to their spirituality which were excluded on the basis that they are difficult to measure, yet still could be affecting their health, such as environmental factors. Some of the participants did not always state in what way spirituality affects their health. The way the data was collected should also be acknowledged, as it focused on how spirituality affects health, not how health affects spirituality. This research only focused on the UK population who identified as SBNR.

4.9.2 Summary

SHEM helps illustrate how some individuals perceive the relationship between spirituality and health. Although there are several limitations with the SHEM diagram, it helps to give a clearer picture of the results of this study's findings and the relationship between spirituality and health. In answer to objective five of this study (and the overall aim of the study), the proposed benefits of the relationship are seen to be the result of a collection of inter-related and interacting factors. The results of this study illustrate that some people perceive spirituality to have an impact on different dimensions of health. This study looked at personal beliefs and spiritual practices and identified some of the mechanisms through which the beneficial effects occur. This includes motivation, different coping styles, and a wide range of support networks in times of stress or physiological responses to spiritual activities. These may well interact with many individual factors, including a person's life experience, pre-existing health status, age, gender or cultural background.

4.10 Demographic factors

Objective five: to explore whether the demographic factors impact spirituality and the participants' health.

A wide range of variables can affect spiritual beliefs and health, including gender, age, educational achievement, life experience, ethnicity, place of birth and social class (Dahlgren and Whitehead, 2006). In this section, the following participant demographics were explored: gender, age, education, employment status, income, ethnicity, and place of birth. The data are presented in sequential order. The tables discussing the spiritual practices in relation to a particular demographic factor bring together findings from the question: 'do you engage in spiritual practice(s)?' The mean scores for the impact of spirituality on the different health dimensions, separated by specific demographic factors (for example, gender and age) were then explored. In this section, the 'prefer not to say' responses and the missing data were grouped together to make presenting and evaluating the results easier.

Overview of the questionnaire participants

Out of the 759 questionnaire participants, 59% (n=448) of the participants were female, 33.5% (n=254) were male, 6.8% (n=52) preferred not to say and 0.7% (n=5) responded to 'other'. The majority (n=688; 90.7%) of the participants were aged between 18 and 65, and the questionnaire participants had a range of educational backgrounds ranging from no formal education to an array of qualifications. Over half (n=511; 67.3%) of the participants were employed, within a wide range of different roles (such as IT consultant, chef, carer, and data analyst). Almost a quarter of participants (n=161; 21.3%) did not work at all, and 87 (11.4%) did not state their profession. 562 (74%) of the questionnaire participants reported to be White British. In terms of place of birth, 71.8% (n=579) of the questionnaire participants were born in England, 15.8% (n=145) were born in either Wales, Scotland, Northern Ireland or outside of the UK, and 11.6% (n=87) preferred not to state their place of birth.

Gender and spirituality

Table 35: Spiritual practices by gender

		Spiritual practices		
Gender	**Total**	**Engage with spiritual practices**	**Do not engage with spiritual practices**	**Not sure**
	n(%)	**n(%)**	**n(%)**	**n(%)**
Female	**448 (59)**	235 (52.4)	180 (40.2)	33 (7.4)
Male	**254 (33.5)**	149 (58.7)	84 (33.1)	21 (8.3)
Other	**5 (0.7)**	5 (100)	-	-
Prefer not to say	**52 (6.8)**	28 (53.8)	24 (46.2)	-
Total	**759**	417	288	53

Out of the 759 questionnaire participants, 59% (n=448) of the participants were female, 33.5% (n=254) were male, 6.8% (n=52) preferred not to say and 0.7% (n=5) respond to 'other'. Table 35 shows that more females (194; 27.6%) than males participated in the questionnaire. A slightly higher percentage of males (6.3%) engaged in spiritual practices than females.

Table 36: Gender, spirituality and health

		Dimensions of health					
		Physical health dimension	**Mental health dimension**	**Emotional health dimension**	**Social health dimension**	**Societal health dimension**	**Spiritual health dimension**
Gender	**Total n(%)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**
Female	**448 (59)**	3.71 (0.76)	3.95 (0.81)	4.34 (0.77)	3.72 (0.75)	3.84 (0.77)	4.05 (0.78)
Male	**254 (33.5)**	3.8 (0.79)	3.95 (0.82)	4.29 (0.85)	3.67 (0.79)	3.78 (0.8)	4 (0.82)
Other	**5 (0.7)**	2.08 (1.53)	2.25 (2.3)	2.63 (1.77)	2.3 (1.84)	2.5 (2.12)	2.25 (1.77)
Prefer not to say	**52 (6.8)**	3.74 (0.61)	3.91 (0.79)	3.71 (0.67)	3.81 (0.76)	3.87 (0.80)	3.88 (0.93)

Table 36 shows that in relation to the questionnaire participants' gender, there was only a small variation in the mean scores of the reported impact of spirituality on health. Overall, the emotional and spiritual health dimensions were perceived to be impacted by spirituality the most, compared with other dimensions of health across all genders. Interestingly, compared to the other genders, those who identified themselves as 'other' perceived spirituality to have less of an effect on all health dimensions. However, as this subgroup only consisted of five participants, this made it difficult to draw a meaningful conclusion about the data, as it is not a large enough sample (however, this could be explored in another study). Moreover, the 'prefer not to say' group followed a similar pattern to the rest, demonstrating consistency in the data.

Age and spirituality

Table 37: Spiritual practices by age

		Spiritual practices		
Age	**Total**	**Engage with Spiritual Practices**	**Do not engage with Spiritual Practices**	**Not sure**
	n(%)	**n(%)**	**n(%)**	**n(%)**
18-30	**199 (26.2)**	66 (33.2)	104 (52.3)	29 (14.6)
31-40	**153 (20.2)**	92 (60.1)	53 (34.6)	8 (5.2)
41-50	**164 (21.6)**	105 (64)	50 (30.5)	9 (5.5)
51-65	**172 (22.7)**	107 (62.2)	57 (33.1)	8 (4.7)
66+	**35 (4.6)**	24 (68.6)	10 (28.6)	1 (2.8)
Prefer not to say	**36 (4.7)**	22 (61.1)	14 (38.9)	-
Total	**759**	417	288	54

Table 37 presents the participants' ages in relation to whether they reported engaging in spiritual practices. The majority (n=688; 90.7%) of the participants were aged between 18 and 65. Only 35 (4.6%) participants reported to be over 66, and just 33.2% (n=66) of those aged 18-30 participated in spiritual practices. Throughout the age categories, only a small percentage of participants were unsure if they engaged in spiritual practices, with the age category (31+) demonstrating a higher percentage (on average almost 50% more) of spiritual engagement.

Table 38: Age, spirituality and health

		Dimensions of health					
		Physical health dimension	**Mental health dimension**	**Emotional health dimension**	**Social health dimension**	**Societal health dimension**	**Spiritual health dimension**
Age	**Total n(%)**	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**
18-30	**199 (26.2)**	3.58 (0.76)	3.75 (0.85)	4 (0.84)	3.51 (0.77)	3.66 (0.84)	3.8 (0.8)
31-40	**153 (20.2)**	3.84 (0.75)	4.01 (0.86)	4.7 (0.77)	3.74 (0.74)	3.83 (0.76)	4.09 (0.75)
41-50	**164 (21.6)**	3.86 (0.79)	4.16 (0.84)	4.41 (0.81)	3.89 (0.79)	3.98 (0.83)	4.27 (0.8)
51-65	**172 (22.7)**	3.82 (0.74)	3.96 (0.8)	4.42 (0.81)	3.72 (0.74)	3.46 (0.74)	4.08 (0.83)
66+	**35 (4.6)**	3.84 (0.97)	3.93 (0.55)	4.19 (0.68)	3.75 (0.74)	3.91 (0.70)	4.07 (0.7)
Prefer not to say	**36 (4.7)**	3.59 (0.63)	3.81 (0.76)	3.3 (0.49)	3.59 (0.69)	3.7 (0.77)	3.71 (0.9)

Table 38 shows mean scores for the perceived impact of spirituality on the different health dimensions, compared by age group. Generally, participants over the age of 31 reported spirituality to have a slightly higher impact on all of their dimensions of health. Within the health dimensions more broadly, emotional health had a higher mean score compared to the rest of the health dimensions across all age groups (apart from prefer not to say), with emotional health scoring highest amongst 18 - 30 year olds.

Education and spirituality

Table 39: Spiritual practices by educational attainment

		Spiritual practices		
Educational attainment	**Total**	**Engage with Spiritual Practices**	**Do not engage with Spiritual Practices**	**Not sure**
	n(%)	**n(%)**	**n(%)**	**n(%)**
No qualifications	**26 (3.4)**	16 (61.5)	9 (34.6)	1 (3.8)
GCSEs or equivalent	**124 (16.3)**	67 (54.8)	47 (37.9)	10 (7.3)
A-Levels or Equivalent	**200 (26.4)**	94 (47)	89 (45)	17 (8)
Degree	**208 (27.4)**	117 (56.3)	73 (35.1)	18 (8.7)
Postgraduate qualification	**147 (19.4)**	104 (70.8)	35 (23.8)	8 (5.4)
Prefer not to say	**54 (7.1)**	19 (35.2)	35 (64.8)	-
Total	**759**	417	288	54

Table 39 demonstrates that there was not a large variation in spiritual practices between participants with differing levels of education. The majority of the questionnaire participants reported to have educational qualifications, and most had attained A-levels or higher (n=555; 73.2%). There was not a large variety of differences between educational attainment and spiritual practices, and slightly less with A levels (or equivalent) engaged in spiritual practices. Compared to age and gender, an increase in the number of the questionnaire participants selected 'prefer not to say' to the education question. This may be due to participants thinking it was a personal question or not relevant to the rest of the questionnaire.

Table 40: Education, spirituality and health

		Dimensions of health					
Qualification	**Total**	**Physical health dimension**	**Mental health dimension**	**Emotional health dimension**	**Social health dimension**	**Societal health dimension**	**Spiritual health dimension**
	n(%)	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**	**Mean(SD)**
No qualification	**26 (2.8)**	3.72 (.97)	3.91 (1.02)	3.98 (1.06)	3.75 (0.84)	3.87 (0.99)	4.22 (0.89)
GCSEs or equivalent	**124 (13.5)**	3.66 (0.88)	3.83 (0.91)	4.01 (0.9)	3.62 (0.83)	3.72 (0.85)	3.95 (0.76)
A-Levels or Equivalent	**200 (21.8)**	3.69 (0.77)	3.88 (0.87)	4.41 (0.81)	3.68 (0.82)	3.72 (0.80)	3.9 (0.84)
Degree	**208 (22.7)**	3.82 (0.71)	4 (0.79)	4.43 (0.81)	3.72 (0.73)	3.87 (0.77)	4.13 (0.79)
Postgraduate qualification	**147 (16)**	3.85 (0.78)	4.02 (0.7)	4.46 (0.72)	3.71 (0.73)	3.91 (0.72)	4.06 (0.77)
Prefer not to say	**212 (23.2)**	3.66 (0.59)	3.8 (0.78)	3.54 (0.5)	3.65 (0.70)	3.7 (0.74)	3.69 (0.91)

Table 40 demonstrates that education did not seem to be a factor that influenced how much the participants thought spirituality affected a particular dimension of health. For emotional health, postgraduate qualification was slightly higher than no qualification. Those with A levels or higher presented a slightly higher mental and emotional dimensions. The participants who reported no qualifications mean score was higher than the rest of the other dimensions of health, demonstrating that spirituality to have the greatest influence on spiritual health.

Employment and spirituality

In this study, 511 (67.3%) questionnaire participants were employed. They were employed in a wide range of different professions. For the questionnaire, participants who reported no employment (n=161; 21.3%), reasons included being retired or not fit enough to work. Some did not work due to being 'informal' carers, stay-at-home parents, or just not needing an income. Employment was categorised by sector (the italicised quotes below are examples of some of the questionnaire participants' answers):

- Health and medical-related services (n=117; 22.9%) – '*carer,' 'nurse, 'medical doctor'.*
- Management (n=68; 13.3%) – *'business manager', 'manager of a team'.*
- Academic (n=65; 12.7%) – '*teacher,' 'lecturer'.*
- Office-based job (n=65; 12.7%) – '*secretary', 'receptionist'.*
- Hospitality and catering roles (n=45; 8.8%) – '*chef', 'cleaner'.*
- Retail (n=35; 6.8%) – '*shop assistant', 'cashier*'.
- Trade job role (n=28; 5.5%) – '*carpenter,' 'builder,' 'painter and decorator*'.
- Art and design roles (n=21; 4.1%) – '*architect, artist, interior designer*'.
- Civil servants (n=11; 2.1%) – '*police officer,' 'Border Force officer*'.
- Other (n=18; 3.5%) – '*lifeguard,' 'journalist,' 'water analyst'.*

Table 41: Spiritual practices by employment status

		Spiritual practices		
Employment status	**Total n(%)**	**Engage with spiritual practices n(%)**	**Do not engage with spiritual practices n(%)**	**Not sure n(%)**
Employed	**511 (67.3)**	270 (52.8)	201 (39.9)	40 (7.2)
Not employed	**161 (21.3)**	99 (61.5)	51 (31.7)	11 (6.8)
Prefer not to say	**87 (11.4)**	48 (55.2)	36 (41.4)	3 (3.4)
Total	**759**	417	288	54

Over half (n=511; 67.3%) of the participants were employed within a wide range of different roles (such as IT consultant, chef, carer, and data analyst). Almost a quarter of participants (n=161; 21.3%) did not work at all, and 87 (11.4%) did not state their profession. Table 41 illustrates that when considering employment status, there was little variation in spiritual practices, although there was a slightly higher figure of participants who were unemployed and engaged in spiritual practices (8.7%).

Table 42: Employment, spirituality and health

		Dimensions of health					
		Physical health dimension	**Mental health dimension**	**Emotional health dimension**	**Social health dimension**	**Societal health dimension**	**Spiritual health dimension**
Employment status	**Total n(%)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**
Employed	**511 (67.3)**	3.82 (0.75)	4.24 (0.82)	4.02 (0.82)	3.78 (0.79)	3.9 (0.80)	4.08 (0.81)
Not employed	**161 (21.3)**	4.41 (0.82)	3.76 (0.82)	4.02 (0.78)	4.43 (0.73)	2.72 (0.75)	4.9 (0.82)
Prefer not to say	**87 (11.4)**	3.55 (0.71)	3.88 (0.77)	3.56 (0.48)	3.64 (0.67)	3.65 (0.69)	3.7 (0.85)

Table 42 demonstrates that spirituality was reported to impact the physical and social health of unemployed participants more than of employed participants. Those who were employed perceived spirituality to have more of an impact on their mental and societal health than those who were unemployed, yet emphasis on overall spiritual health remained high.

Income and spirituality

Table 43: Spiritual practices by annual income

		Spiritual practices		
Annual Income	**Total n(%)**	**Engage with spiritual practices n(%)**	**Do not engage with spiritual practices n(%)**	**Not sure n(%)**
0-£15,000	**199 (26.2)**	93 (46.7)	90 (45.2)	16 (8)
£15,000-£30,000	**177 (23.3)**	95 (53.7)	74 (41.8)	8 (4.5)
£30,000-£50,000	**79 (10.4)**	41 (51.9)	31 (39.2)	7 (8.9)
£50,000-£100,000	**30 (4)**	15 (50)	13 (43.3)	2 (6.7)
£100,000 +	**6 (0.8)**	4 (66.7)	2 (33.3)	-
Prefer not to say	**268 (35.3)**	169 (63.1)	78 (29.1)	21 (7.8)
Total	**759**	417	288	54

Table 43 illustrates that the questionnaire participants earned a wide range of incomes. Almost a third of the participants earned between £0-£15,000, yet over a third of the participants (n=268; 35.3%) chose not to answer the question about their income. This could be due to income being viewed as a private matter or not relevant to this study by the participants. A slightly higher percentage (13%) of those who earned £100,000+ seemed to engage in spiritual practices compared to the other participants. However, due to the large number of participants who did not answer this question, it was challenging to make definitive judgments regarding earnings and spirituality.

Table 44: Income, spirituality and health

		Dimensions of health					
		Physical health dimension	**Mental health dimension**	**Emotional health dimension**	**Social health dimension**	**Societal health dimension**	**Spiritual health dimension**
Income	**Total n(%)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**
0-£15,000	**199 (26.2)**	3.64 (0.76)	3.85 (0.83)	2.3 (0.81)	4.53 (0.8)	2.83 (0.79)	3.91 (0.82)
£16,000-£30,000	**177 (23.3)**	3.77 (0.71)	4.01 (0.73)	4.27 (0.84)	4.72 (0.73)	2.9 (0.78)	4.09 (0.74)
£31,000-£49,000	**79 (10.4)**	3.85 (0.77)	3.96 (0.76)	4.08 (0.71)	4.66 (0.69)	2.78 (0.76)	3.89 (0.78)
£50,000-£100,000	**30 (4)**	3.72 (0.64)	3.79 (0.79)	3.88 (0.76)	4.66 (0.76)	2.75 (0.79)	3.52 (0.76)
£100,000 +	**6 (0.8)**	3.64 (1.58)	3.85 (1.61)	4.04 (1.6)	4.53 (1.6)	2.76 (1.63)	3.91 (1.51)
Prefer not to say	**268 (35.3)**	3.74 (0.86)	4.14 (0.79)	3.82 (0.73)	3.64 (0.76)	4.88 (0.76)	3.99 (0.85)

Table 44 shows that there was perceived to be less of an impact of spirituality on societal health than all the other dimensions of health across the entirety of questionnaire participants, apart from those who preferred not to disclose their income. Emotional health was also low in those who earnt £0-£15,000. As noted already, it was challenging to make definitive judgments regarding earnings and spirituality in relation to the participants' health due to the large number of participants who did not answer this question (however, this is an area that could be explored in a future study).

Ethnicity and spirituality

The majority of the questionnaire participants identified as White British (n=562; 74%) and 26% (n=197) of the participants identified as being from a different ethnic background. These participants were from the following groups: White Irish (n=1; 0.5%); any other White background (n=27; 13.8%); mixed White and black Caribbean (n=8; 4.2%); mixed White and black African; (n=3; 1.5%), White and Asian; (n=5; 2.5%); mixed/multiple ethnic groups (n=7; 3.5%); other mixed/multiple ethnic background (n=1; 0.5%); Asian (n=7; 3.5%); Indian (n=5; 2.5%); Bangladeshi (n=1; 0.5%); Chinese (n=2; 1%); other Asian background (n=2; 1%); Black/African/Caribbean/Black British (n=2; 1%); African (n=3; 1.5%); Caribbean (n=2; 1%); other ethnic groups and prefer not to say (n=121; 61.5%). In comparison to the White British group, the other groups were small, therefore they were grouped together in Table 45.

Table 45: Spiritual practices by ethnicity

		Spiritual practices		
Ethnicity	**Total** **n(%)**	**Engage with spiritual practices** **n(%)**	**Do not engage with spiritual practices** **n(%)**	**Not sure** **n(%)**
White British*	**562 (74)**	286 (50.9)	231 (41.1)	45 (8)
Other**	**197 (26)**	131 (66.5)	57 (28.9)	9 (4.6)
Total	**759**	417	288	54

* This group includes participants whose ethnicities are: English/Welsh/Scottish/Northern Irish/British.
** This group consists of participants from other ethnic groups and those who preferred not to state their ethnicity.

Table 45 shows that ethnicity did not appear to be a factor that was reported to affect engagement in spirituality. Nevertheless, there is not enough information to make definitive judgments from this data, as due to small sample sizes, many of the ethnic groups were grouped together (including the prefer not to say data). Data on ethnicity in relation to the dimensions of health were not presented as the group sample sizes were so small that it was difficult to draw meaningful conclusions about this data.

Place of birth and spirituality

In relation to birthplace and spirituality, the majority of the questionnaire participants stated that they were born in England (n=540; 71.8%). The other participants were born in Scotland (n=43; 5.7%), Wales (n=17; 2.2%), Northern Ireland (n=14; 1.8%), and outside of the UK (n=58; 7.6%). Compared to people born in England, the other groups were small. Therefore, they were grouped together in Table 46.

Table 46: Spiritual practices by place of birth

		Spiritual practices		
Place of birth	**Total n(%)**	**Engage with spiritual practices**	**Do not engage with spiritual practices**	**Not sure**
England	**540 (71.8)**	291 (53.9)	239 (44.3)	10 (1.8)
Other*	**132 (17.6)**	102 (77.3)	30 (22.7)	-
Prefer not to say	**87 (11.6)**	24 (27.6)	19 (21.8)	44 (50.6)
Total	**759**	417	288	54

* This group includes all participants born in: Wales, Scotland, Northern Ireland and outside the UK.

Table 46 demonstrates that of those participants born in Scotland, Wales, Northern Ireland and outside of the UK, there was a 23% increase in engagement in spiritual practices compared to those born in England. Data on place of birth in relation to the dimensions of health were not presented as the group sample sizes were so small that it would be difficult to draw meaningful conclusions about this data.

4.10.1 Summary

With the questionnaire participants' demographics, there was some variation between participants' answers. There were more females than males who engaged in this research, yet overall, gender did not seem to be a factor that affected the mean scores, as there were only small variations between the dimensions of health and spirituality. Slightly more (6.3%) males than females engaged in spiritual practices, and even though more women than men filled in the questionnaire, even more women may have participated due to their increased interest in spirituality and openness to online questionnaire engagement. In relation to age, only 33% of those aged 18-30 declared engagement in spiritual practices. Generally, the questionnaire participants over the age of 30 perceived a more positive relationship between spirituality and dimensions of health.

The results showed there was not a mass variation between education and spiritual practices. However, a majority of the participants had A levels or more, and came from a wide range of professions. Many participants chose not to answer the questions relating to income; this may be due to the perception of irrelevancy, confidentiality or loss of interest at this part of the questionnaire. Furthermore, most of the participants were born in the UK and were white British, though this factor did not seem to affect the relationship between spiritual practices and health. However, 20% more participants born outside of England reported engaging in spiritual practices than those born in England.

4.11 Missing data

Missing data were dealt with by acknowledging it when there was missing data and categorising it appropriately. Out of all the people who started the questionnaire, 201 participants stopped responding after the first three questions. With the quantitative data between 0% - 30% of the data is missing in the result tables (as illustrated in each table). This may have been due to participants losing interest, as perhaps the questionnaire was too long. However, having missing data is common in survey research (Dancey, Reidy and Rowe, 2012; Saks and Allsop, 2012).

Some of the questionnaire participants chose not to answer questions that could be considered to ask for 'sensitive information' such as income or gender. Another reason for the missing data could be that the participants thought this data was irrelevant to the subject or felt the question was irrelevant to them (Dancey, Reidy and Rowe, 2012); this was indicated in a few of the participants' answers. Another plausible explanation for why there are more missing data at the end of the questionnaire is that the demographic questions were asked at the end, and the respondents chose to discontinue

before they came to this part of the questionnaire. None of the questionnaire or interview participants decided to withdraw their answers, during and after the interviews were conducted.

4.12 Chapter Summary

The preceding study has demonstrated that many of the participants described themselves as healthy; those who identified themselves as 'not healthy' reported that this was due to physical issues, mental illness or their personal lifestyle choices (objective one). In relation to how spirituality was described (objective two), some of the participants note difficulty describing spirituality. The questionnaire and interview results have demonstrated that spirituality could be seen as a concept that is made up of six themes: connection, self, beliefs, values, deeper awareness and experiences (Figure 9). Not all of these findings were supported by Table 25 (Phrases that have a bearing on the participants' own sense of spirituality), however this may be due to the phrasing of the question.

Regarding objective three, the results suggest that the participants' main spiritual practices included: meditation, prayer, yoga, walking in nature, going to a spiritual building and giving/receiving healing. Over half of the questionnaire participants in this study engaged with spiritual activities at least once a week, practising anywhere they felt appropriate. For some of these participants, spiritual practices were reported to be beneficial to their health as they felt happier, experienced relief when previously ill, felt stress and anxiety reduce, and perceived a change in their physiology. The type and degree of positive influence varied with each participant.

Within both the questionnaire and interview results, most participants thought there was a positive relationship between spirituality and at least one dimension of their health (objective four). The proposed health benefits of spirituality were seen to result from a collection of interrelated and interacting themes (some of which may yet to be discovered). These themes are illustrated by the SHEM model (Figure 10). The results suggest that spirituality is a way of life for many of the participants in this study, and it can be an essential aspect of their human existence. For many participants, spirituality was reported to be a way to give structure, meaning and direction to a person's life, which helps them to deal with 'everyday living'. This, in turn, was a way to promote good health, connect with others, and be a means of finding inner peace and meaning in their lives. On average, a quarter of the participants perceived that spirituality had no effect on their health, and a small percentage (Average 4%) stated it had a negative effect on their health. However, the consensus was that it had an overall positive reported relationship with health. The highest positive relationship reported was between emotional health and spirituality. When joining all these health dimensions together, some participants perceived that spirituality could improve a range of factors, including

exercise, sleep, diet, self-esteem, friendships and a feeling of peace. These are all underlying mechanisms that some participants perceive to benefit many areas of health. For example, findings indicate that participants believed they slept better due to increased exercise, and some participants stated that they were happier due to their spiritual beliefs, improving self-esteem.

The results of this study found that despite spirituality enabling happier feelings, at times it also made some participants feel disconnected from others. Despite this, the results show that there was a positive effect of spirituality for most of the participants, particularly on their emotional and mental health. Many repeatedly expressed that spirituality made them feel happy, safe, and at peace, and that these attributes contributed to their good mental health. They also believed that the relationship between their spirituality and physical health was positive, reporting that the beneficial effects can occur via several different mechanisms; for example, they can be due to different styles of coping, providing motivation, adopting a positive locus of control and having a support network(s).

The demographic factors (objective five) identified that this study's questionnaire and interview participants were quite diverse in terms of their backgrounds. There was some variation between the participants' answers and those who participated in this study (for example, more women than men engaging in the research). The participants' gender did not seem to be a factor that considerably affected the mean scores between health and spirituality, and most of the participants aged 18-30 defined themselves as spiritual. However, only 33.2% (n=66) of those aged 18-30 took part in spiritual practices. Generally, the participants over the age of 30 had a stronger positive relationship between spirituality and health. The majority of the questionnaire participants reported to have educational qualifications, and most had attained A-levels or higher (n=555; 73.2%). There was not a large variety of differences between educational attainment and spiritual practices. Over half (n=511; 67.3%) of the participants were employed within a wide range of different roles (such as IT consultant, chef, carer, and data analyst). Almost a quarter of participants (n=161; 21.3%) did not work at all, and 87 (11.4%) did not state their profession.

Almost a third of the participants earned £0-£15,000 and chose not to answer the question about their income (n=268; 35.3%). This could be due to income being viewed as a private matter or not relevant to this study by the participants. Yet, a slightly higher percentage (13%) of those who earned £100,000+ seemed to engage in spiritual practices compared to the other participants. The ethnicity and place of birth as a variable did not appear to have an impact on participants` spiritual practices.

There were some limitations with the questionnaire results (discussed in depth in section 5.7). First, a lack of clarity in some of the responses; participants seemed to conflate two concepts together, such as stress and anxiety, so it was not always clear which one they were referring to; second, there was

variation and a lack of clarity and separation between social and societal health; third, grouping together varied spiritual activities (for example, card reading and yoga) which made the findings problematic to measure. As the various dimensions of health are also interlinked, it was difficult to isolate them; for example, a person's positive physical health might result from good social health. This needs to be considered when considering how credible the questionnaire and findings are. Finally, whilst a very small minority reported spirituality as causing harm to their health, for the many, it was perceived as having a positive impact across all dimensions of health.

Chapter Five

Discussion

5.0 Introduction

The following discussion chapter considers the findings of and contributions to knowledge this thesis makes to the field of Public Health. In line with the objectives (discussed in section 1.6), the chapter is divided into eight sections. Section 5.1 examines the health of the participants in order to address objective one. Section 5.2 discusses how this research builds and supports other research definitions of spirituality, addressing objective two, and 5.3, concerned with objective three, seeks to provide new scholarship surrounding individual engagement into spiritual practices. Following on from this, section 5.4 explore how spirituality impacts different dimensions of health, while addressing objective four, and 5.5 discusses demographic factors that have an impact on the relationship between spirituality and health in order to engage with objective five. Section 5.6 considers the potential purpose of SHEM and its contribution to Public Health, and in conclusion, 5.7 outlines the potential limitations of this research, whilst 5.8 summarises the findings of the discussion chapter.

Selecting the relevant findings

Due to the large amount of data generated (918 questionnaires and 24 interviews), it is not possible to discuss all of the findings in this discussion chapter. As a result, only the relevant data contributing to new knowledge concerning this thesis`s objectives are discussed. In this chapter, the words in italics and quotation marks are quotes from the participants.

5.1 The health of the participants

Through the research gathered from the literature review, it was identified that much of the existing scholarship on the subject was centred on people undergoing medical treatment or the elderly (for example, Hosseini, Chaurasia and Oremus, 2019; Hulett and Armer, 2016; Liefbroer et al., 2017; Schreiber and Brockopp, 2012; Thune-Boyle et al., 2006). However, a gap in research was identified concerning individuals who were reported to be healthy, resulting in the subject of this study. 83% (n=759) of the questionnaire participants stated that they considered themselves healthy, 6% (n=54) were not sure, and 11% (n=104) responded ‘no’, that they did not consider themselves to be healthy. In the latter response, participants' main reasons were long-term illness, mental health issues, and poor lifestyle choices (as defined by the participants). Individuals who identified as healthy were chosen to participate in the interviews, and their answers were vital to meeting objective one of this study and providing critical frameworks for understanding self-perception and ‘healthy’ subjects.

Despite the importance of this framework for existing research, it is important to note a potential limitation of this approach, namely, that 'health' is in itself a subjective state. For example, an individual who takes a pill to ensure their blood pressure is continuously normal may be considered healthy by some, whilst others perceive them as unhealthy for requiring medication (Boyd, 2021). Furthermore, within this study's framework, 'health' was determined by self-perception, not physiological state. Despite these potential pitfalls, it is beyond the remit of this study to decipher individual perceptions in regard to what constitutes 'health'. However, this avenue has the potential to be addressed in future research with a focus on idiosyncratic participant definitions of 'health' and its meaning.

5.2 Describing themes of spirituality

The study successfully met objective two by collating definitions of spirituality from the participants' points of view. In order to demonstrate how objective two was met, the next section is divided into three sections: 5.2.1 discusses the difficulties inherent in obtaining a sound definition of spirituality. Section 5.2.2 seeks to set out and evaluate the themes of spirituality the research has identified, and finally, 5.2.3 endeavours to describe spirituality in the context of Public Health.

5.2.1 Difficulty defining spirituality

As highlighted at the beginning of this thesis, the complexities of defining spirituality are well recognised (Clarke, 2013; Damiano, Lucchetti and Peres, 2021; Narayanasamy, 2001). Interestingly, participants of the current study also highlighted the difficulties of defining spirituality in the context of its status as *'hard to verbalise'*. In this light, Jones (2016) and Wattis, Curran and Rogers (2017) similarly argue that spirituality is a nebulous concept that makes it complicated to describe. In a similar vein, Kourie (2007) claims that the term spirituality is difficult to define, given the equivocal meanings and the tendency to equate this phenomenon with piety or otherworldliness. This difficulty is recognised across the health disciplines, such as nursing literature and by other health professionals within their own practice (Ali, 2017; Jones, 2016; McSherry, 2007; Oman, 2018). Therefore, although the difficulty in defining spirituality needs to be recognised in a Public Health context, and calls for the setting out of 'common ground'. Indeed, disregarding the existence of definition difficulty would be misleading and potentially harmful to some people's health (Koenig et al., 2012; Oman, 2018; Oman and Thoresen, 2005). As a result, I argue that a consensus is required concerning 'what spirituality is' so that it can be (further) applied to Public Health in the UK.

5.2.2 Six themes of spirituality

Although this study identified difficulty defining spirituality across the literature, there was an existing consensus of themes. This included individualism (Lewis, 2008), connection (Burkhardt and Nagai-Jacobson, 2002; Mattis, 2002; Tanyi, 2002; Zinnbauer et al., 2015), self-actualisation/self-acceptance (Holt, 2016), and values (Bassett, Lloyd and Tse, 2008; Crawford, Wright and Masten, 2006; Doris, 2010; Foster, 2008; Greenstreet, 2006; Knapik et al., 2010; Nygren et al., 2005; Park 2007; Tanyi, 2002; Waaijman, 2002). The results of this exploratory study identified six themes that can be used to potentially describe spirituality: connection, self, belief, values, deeper awareness, and experiences. These themes in the existing literature and the current study reflect the multiple ways of understanding and experiencing spirituality (Cawley, 1997; Greenstreet, 2001; Koenig, 2014; McCarroll et al., 2005; Paloutzian and Park, 2014; Tanyi, 2002). The following sections discuss these six themes and situate them within the existing literature.

5.2.3 Connection

The theme 'connection' was found both in the current data and within the existing literature (Burkhardt and Nagai-Jacobson, 2002; Mattis, 2002; Tanyi, 2002; Zinnbauer et al., 2015), thus revealing consistency in both areas of research. 'Connection' was conceptualised in the data as the participants' relationships with themselves, other people, animals, and their environment. *'*Connection' involved a broad range of complex relationships, such as *'an interconnected relationship to myself and the world about me'*. These findings were also echoed by Kang (2003), who found that 'connection' was reported within the literature as an experience of belonging to others, nature and family regarding defining spirituality. Existing literature implies connection is acted out in practice by facilitating connections with communities (including faith communities) and spiritual practices such as prayer, meditation and worship (Egan and Swedersky, 2003; Taylor et al., 2000). However, this could be criticised, as not everyone may incorporate connection in their definition of spirituality. For example, Spencer (2012, p.1) claims that 'spirituality involves the recognition of a feeling or sense or belief that there is something greater than me, something more to being human than sensory experience, and that the greater whole of which we are part is cosmic or divine in nature'. Despite this, there is general agreement that connection is part of the definition of spirituality.

5.2.4 Self

The theme of looking after the individual 'self' was part of the participants' definition of spirituality. Comments included, '*a sense of self', 'self-improvement'*, and *'self-growth'*. However, at the same

time, they also felt they had a *'moral duty to look after'* and '*connect with others'*. Scholarship has noted that 'personalisation' is an aspect of spirituality (Kelly and Eddie, 2020; Mercadante, 2020; Saunders et al., 2020; Van der Tempel and Moodley, 2020; Watts, 2019; Willard and Norenzayan, 2017), and both 'the self' and personalisation can be seen as similar concepts because they both refer to the self. The 'self' was also included in Tuck`s (2007) definition of *spirituality*, who described *spirituality* as an 'awareness' and 'essential part of the *self'*. One possible concern with the focus on the 'self' in this research, and more specifically in the SHEM map, is that it is arguably culturally and socially constructed, can be a determinant of health (Hay, 2000), and may affirm the potentially difficult culture of 'extreme individualism'. However, Michaelson et al. (2019, p.17) have argued that the 'development of a sense of self can be vital to positive mental health'. Therefore, by default, this sense of self, as part of spirituality, might be beneficial to people's lives, supporting the rationale for inclusion in a description of the theme of spirituality.

Self-development

In relation to spirituality, the theme 'self-development' ('*improving the self*') was highlighted as essential to individuals' being, emphasising introspection, or reflective action to improve the self. To further support the self as a theme of spirituality, Cassar and Shinebourne (2012) found that their participants described how they used spirituality as a self-development tool that helped them relate to others more positively. The theme 'self-development' was also echoed in Li (2014), Parsons, Houge Mackenzie and Filep (2019), and Pirnazarov`s (2021) definition of spirituality. However, the theme 'self-development' was not always an explicit theme of spirituality within the literature; for example, Hulett and Armer (2016, p.406) posit spirituality as a 'subjective experience of the sacred' which 'refers to an emotional connectedness or relationship with God or the transcendent beyond the self'. This definition is supported by Saunders et al. (2020), who describe spirituality as a dynamic and intrinsic aspect of humanity through the search for ultimate meaning, purpose, transcendence, and experience. It could be argued that spirituality cannot be seen as a form of self-development because it is nebulous, and self-development could be perceived as an abstract concept like spirituality (Alma, 2008; Jones, 2016; Li, 2014); therefore, it can also be challenging to measure. This could be seen as a wider criticism of this research. Several abstract concepts are used when discussing spirituality (for example, inner self, connection, and transcendence), consequently adding to its ambiguity. Despite this, the literature by Mercadante (2014) and Mercadante (2020) argued that some people who identify as SBNR define spirituality as a valuable means of furthering spiritual growth. This culminates in supporting self-development as part of the theme of spirituality.

Inner self

The results of this study point towards more people viewing themselves as individuals who are focused on the 'inner self' (‘*development of the inner self*'; *'part of personal growth'*). These findings are supported by Parsian and Dunning (2009, p.100), who refers to spirituality as the ‘inner self that empowers people to manage difficult situations and helps them find meaning in life situations and connect with other people and the universal whole’. They argue that spirituality encompasses reflecting on life events, coping with obstacles, and ultimately achieving acceptance and inner peace (Parsian and Dunning, 2009). Similarly, Kenneson (2015, p.3) posited that many of those who identified as SBNR defined spirituality as 'private reflection and private experience - not public ritual', thus pointing towards the notion of the ‘inner self’. However, as discussed above, a criticism of this view is that the term ‘inner self’ could be seen as an abstract concept, and therefore difficult to apply within a Public Health context. Many of the participants in the study explained their understanding of the inner self to be ‘*the personal inner internal identity’.* Supported by this definition is Emmons’ (2003) research, which states its close proximity to a person’s values, beliefs, goals, and motivations. The term ‘inner self’ also implies a level of authenticity not associated with external identities and labels, centring around greater access to the ‘true self’ (Ladkin and Taylor, 2010). In addition, many of the participants refer to the ‘inner self’ as the soul, particularly when describing spirituality (Emmons, 2003; Parsian and Dunning, 2009). Consequently, the findings of the literature and this study demonstrate the ‘inner self’ to be an important theme in defining spirituality.

5.2.5 Belief

For many of those who identified as SBNR, 'belief' was an essential aspect of their definition of spirituality. In this light, belief is understood to be linked closely to something of which an individual hold to be true, where this study’s data pointed towards individual understanding of belief to be associated with the feeling of something more to life than the material world. Research suggests that people traditionally see 'belief' as an aspect of religion (Koenig, 2012), whereas SBNR tends to involve a rejection of religion (Ferrer and Vickery, 2018). This research identified two types of beliefs: 'higher power' and 'transcendence’ discussed in detail below.

Higher Power

The data in this study identified ‘higher power’ as a theme of spirituality. Participants noted its links to positive feelings: '*For me, a 'higher power' gives me a great sense of optimism, hope, a sense of purpose'.* Willard and Norenzayan’s (2017) research supports this conceptualisation of a feeling of ‘higher power’. Moreover, McClure (2017) states that SBNRs are more likely to view God as a Higher

Power or Cosmic Force when compared to those who are both religious and spiritual. Subsequently, it is not surprising that a 'higher power' was one of the themes used to describe spirituality. However, McClure (2017) argues that SBNRs are more likely to reject the perceived moral authority of God or the Bible in favour of an individualistic code of ethics. Indeed, Ferrer and Vickery (2018) claim that difficulties also arise when SBNRs tend to reject religion, raising potential complexities: some SBNRs use the theme of a 'higher power' (when defining spirituality), but disassociate it from the usual parameters of religion and ceremony, such as connection to a higher power through the attendance of church, prayer, or the congregation.

This idea links to the overarching problem of 'spirituality' being seen as an individual concept, which can be divided into three sub-issues: first, there is complexity with the precise language being used; second, there is some confusion over which aspects of religion are being rejected (linking back to the theme of the 'individual self'); third, this can be connected to one's individual worldview (how people understand and make sense of the world) and the context in which they are discussing spirituality. Therefore, these interlocking issues must be considered when defining spirituality for those who identify as SBNR.

The theme of a 'higher power' was also echoed by Willard and Norenzayan (2017), who suggest that SBNRs, with their presumed focus on the privacy of individual experience, offer an opportunity to investigate forms of supernatural belief and experience that often fall under the label of spirituality. This construct is typically overlooked due to the traditional extended focus on organised religions. Mercadante (2020, p.1) further supports this framework, claiming that 'a significant percentage of the SBNRs I met had participated in some form of addiction recovery group. In this, they had either been atheists turned 'spiritual' even accepting a Higher Power or they had come from a religious background but found new ways to make the God-concept relatable, acceptable, non-punitive, and beneficial'. With this in mind, it is unsurprising that the participants of this research demonstrated that 'higher power' was part of their definition and understanding of spirituality. Although Mercadante and this study are concerned with different sample populations, they show consistency within the theme 'higher power' when describing spirituality for this group. As a result, this helps to validate its place when defining spirituality, as a 'higher power' can be seen for some as secularised and separate from religion (Ferrer and Vickery, 2018; Mercadante, 2020; Willard and Norenzayan, 2017).

Transcendence

The current literature identified transcendence as a central theme of spirituality (Hulett and Armer, 2016; Milner et al., 2020; Selman et al., 2011). There has also been relatively new research conducted

in America that shows that 'SBNRs scored higher than religious and non-religious participants on belief in God as an impersonal cosmic force but not as a personal being' (Johnson et al., 2018, p.121). The results of this research and the study by Johnson et al. (2018) reaffirmed that transcendence was a key inherent theme tied up in notions of spirituality for individuals.

This current research considers 'transcendence' as an aspect of spirituality for those who identify as SBNR (‘*beyond human experience’; ‘beyond all physical laws’; ‘the sense of something mystical*’) in the UK. Kang (2003) proposes that the term 'transcendence' is used to describe the existential feelings of a power or force beyond a person, and the capacity to develop strategies to cope by drawing from internal resources. Furthermore, Udell and Chandler (2000) claim that the development of coping strategies, including facilitating end of life conversations (when appropriate) to discuss transcendent or spiritual aspects of life, illustrated the link between transcendence and meaning and purpose. Seaward (2001, p.8) asserts that spirituality involves 'connection to a divine source whatever we call it.' On the other hand, Jose and Taylor (1986, p.16) argue that defining spirituality does not necessitate 'God-talk'. Several authors have followed this latter, humanistic line of thinking by attempting to define secular spirituality as spirituality without any need for a religious/God component (Newby, 1996; Smith, 2000; Wright, 2000). Therefore, by consolidating all the above, transcendence can be considered an important factor in spirituality’s description.

5.2.6 Values

The theme of individual 'values' was used as a way to describe spirituality by the participants in this research and was vastly supported by the previous literature (Bassett, Lloyd and Tse, 2008; Crawford, Wright, and Masten, 2006; Doris, 2010; Foster, 2008; Greenstreet, 2006; Knapik et al., 2010; Nygren et al., 2005; Park 2007; Puchalski et al., 2014; Tanyi, 2002; Waaijman 2002). This study identified that values (‘*being kind to others’; ‘not harm other people’*; ‘*abstain from eating meat and drinking alcohol*') enabled participants to decide what they believed to be right or wrong and how they should behave.

Selman et al. (2011, p.730) discuss this in more depth, concluding that ‘spirituality refers to those beliefs, values, and practices that relate to the search for meaning, purpose, or transcendence, which may or may not include belief in a higher power’. Indeed, the theme of ‘values’ can be understood as to how participants seek to find personal 'meaning and purpose' (Saunders et al., 2020; Van der Tempel and Moodley, 2020). In this light, Chopra (2012) notes that the ‘values’ aspect of the definition enables growth and development and provides a source of support for people. However, values as an aspect of spirituality can be difficult to criticise, as it is intrinsic to people`s beliefs (Dierendonck and Mohan, 2006; Emmons, 2003).

Morals

The participants discussed 'morals' frequently in the study, positing statements such as: '*having a sense of belonging and purpose'* and *'I have morals and values and feel connected to mother earth'*. The theme of morals also had a place in Starov's (2010) and Pirnazarov's (2021) definitions of spirituality. This was supported by McClure (2017), who discovered that personal morals are part of spirituality for those who identify as SBNR, because it emphasises feelings and affections rather than doctrines or practices. Houtman and Mascini (2002) found that radical individualism can be associated with 'moral individualism', which is a critical factor in declining religiosity in the Netherlands, and further linking morals to religion as an aspect of spirituality without the religious element (Houtman and Mascini, 2002). Hirsh, Walberg and Peterson (2013, p.14) reasoned that because 'SBNRs may prefer to do things their own way, their fewer positive attitudes toward religion may reflect liberalism and a perception that religion is too restrictive or structured'. Indeed, personal 'morals', as an aspect of spirituality can be considered an inherent part of people`s deeper beliefs (Dierendonck and Mohan, 2006; Emmons, 2003), and therefore acts as an important framework through which to define spirituality.

Sense of belonging and purpose

The findings of this research highlighted commonly held themes of spirituality, including a 'sense of belonging and purpose.' Some of the participants' comments stated: '*having a sense of belonging and purpose'; 'Spirituality is looking for a sense of belonging and believing in a 'purpose' to life''; 'This can guide people's morals and values and feel connected to mother earth'*. Indeed a 'sense of purpose' was encapsulated by Rosenfield`s (2000, p.17) study as part of their definition of spirituality, in which they state that 'spirituality is meaning-making through purposeful activity'. The theme 'sense of purpose' has also been supported by other previous literature, which suggests acknowledging the importance of each individual's personal definition of spirituality and their perspective of wellness and sense of belonging, which is considered important in describing spirituality in Public Health practice (Egan and Swedersky, 2003; Farrar, 2001; Sumsion and Law, 2006). Individuals 'sense of belonging' as a theme of spirituality is difficult to criticise as it is part of people`s notion of belief (Emmons, 2003). This current research identifies that the subtheme 'sense of purpose' provided a form of 'coping' and 'resilience' for those who self-identify as SBNR (discussed in more depth in section 5.4). Coping and resilience were apparent across the whole range of participants and were highlighted in previous literature (for example, Baetz et al., 2006; Breitbart, 2005; Coyle, 2002; Kaplar, Wachholtz and O'brien, 2004; Nelson et al., 2009).

Emotions

This research showed that emotions are strong feelings deriving from one's circumstances, moods, or relationships with others, including feelings such as '*love*', '*happiness*', '*joyfulness*' and '*sense of belonging*'. There was literature to show that those who identify as SBNRs continue to seek spiritual fulfilment, which was particularly the case when experiencing negative emotions, such as fear, distrust, and anxiety (Mercadante, 2020). Research supports this, as emotions 'touch people's hearts', because they deal with the very essence of 'being' (Fishers, 2011; Jose and Taylor, 1986; Piedmont, 2001). Therefore, it was unsurprising that the participants in this study identified emotions as a theme when describing spirituality. Similar to some of the other themes, criticism of the theme emotion is subjective, and thus challenging to measure (Scollon, Koh and Au, 2011). However, Fuller (2009), Tischler, Biberman and McKeage, (2002) and Vaillant (2008) all included the word 'emotion' within their definition of spirituality, supporting its inclusion in this study as a foundation for defining spirituality.

5.2.7 Deeper awareness

The notion of 'deeper awareness' was a prominent theme used to describe spirituality, widely understood as leading to transformation through inner thoughts and reflection, to reflect upon conscious and subconscious beliefs. For some participants, it was reported that this was to help change their '*energy patterns*' or behaviour '*to live a healthier lifestyle'*. Deeper awareness and profound meaning was also found in Livni (2018) and Niemiec, Russo-Netzer and Pargament's (2020) explanations of spirituality. This theme was supported by Hedlund-de Witt`s (2011) research, who discussed promoting deeper awareness in the context of developing sustainable spirituality. Mooney and Timmins (2007) found that spirituality was considered a universal concept in the student experience of learning about spirituality through the medium of art. They also found that their participants reported 'deeper awareness' as part of their description of spirituality (Mooney and Timmins, 2007). Arguably, however, spirituality is not universal, as it can be personal to the individual (Bash, 2004; Jones, 2016). Once again, a limitation of 'deeper awareness' as a theme is that it can also be seen as subjective and difficult to measure. Despite this, there was scholarly support for deeper awareness to be considered part of spirituality (Hedlund-de Witt, 2011; Mooney and Timmins, 2007).

5.2.8 Experiences

In this study, the theme 'experience' was understood to be an event or occurrence which leaves an impression on someone, or a feeling of a supernatural occurrence that cannot be put into words. This includes encounters that left impressions on some of the participants. Some of the findings from participants included: '*Being at one with nature'; 'Engaging with Nature'; 'Feeling of inner peace'; 'At peace within yourself and others.* Previous literature by Miler et al. (2020) found that 'experiences' were part of people's descriptions of spirituality among adults with mental health difficulties. Although focussing on a different demographic, Miler et al.'s (2020) findings were similar to this research, and Manning (2012) and Uwland-Sikkema et al. (2018) included the theme of 'experiences' as part of their discussion about what was encompassed by the term spirituality.

Furthermore, spirituality was identified as an 'individual experience' by Swinton (2012, p.52). The current study follows this line of enquiry into notions of 'individual experience' by highlighting what spirituality represents to the participants. However, Macmin and Foskett (2004), and Wilding, Muir-Cochrane and May (2006) argue that some participants in their research feared that their spiritual experiences might be interpreted as symptoms of mental illness; therefore, researchers should be mindful of this subjective understanding when using the term 'experiences' to describe spirituality. This notion, that not all spiritual experiences are necessarily positive, needs to be considered when it comes to the description of spirituality, and requires acknowledgement that for some individuals, there is a difference between a spiritual experience and the term 'experience' as a theme of spirituality. Despite this criticism, generally, experiences (whether positive, negative, or indifferent) can still be seen as part of describing spirituality. Therefore, the theme 'experiences' should be considered part of the description of spirituality.

5.2.9 Describing spirituality within Public Health

Spirituality remains a nebulous concept that is difficult to define, leading to many opposing definitions of spirituality (for example, Breitbart, 2005; Fisher, 2011; Greenstreet, 2001; Jones, 2016; Sheldrake, 2013; Vanistendael, 2007; Wattis, Curran and Rogers, 2017). Indeed, spirituality can be perceived as an idiosyncratic process, and therefore appear challenging to define in health care practice (Greenstreet, 2001; Vanistendael, 2007; Wattis, Curran and Rogers, 2017). However, this thesis broaches much consideration to the question of how spirituality within Public Health in the UK can be defined in a way complementary to Public Health practice, and secondly, can effectively contribute to person-centred care (if appropriate).

In this light, the thesis adopts Wattis, Curran and Rogers' (2017, p.4) description of spirituality (which they originally adapted from Cook, 2004). Highlighted in bold are the themes found in this research:

*'Spirituality is distinctive, potentially creative and universal dimension of human experience arising both within the **inner** subjective **experience** of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately 'inner', immanent and personal within the **self** and **others**, and/or as a relationship with that which is wholly 'other', **transcendence** and beyond the self. It is experienced as being fundamental or ultimate importance and is thus concerned with **meaning and purpose** in life, truth and **values**.'*

Wattis, Curran and Roger's recent and timely work into the complementary nature of spirituality and healthcare here proposes spirituality as a complex, idiosyncratic journey for individuals, a finding which is supported through this thesis' participant research. The current studies analysis into the key themes located as central in the participant research, literature review and concept analysis is complementary to the above definition of spirituality, which is strengthened by its open description of, as opposed to a definition of, spirituality, which is often a highly nebulous concept. Healthcare and individuality are two central cruxes to this particular description, making it a useful and effective outline for the current study above other preceding conceptualisations of spirituality in scholarship. Importantly, Wattis, Curran and Rogers note the complementary nature of spirituality and healthcare in terms of practical and educational terms, a relationship this thesis argues is vital to their successful partnership. Therefore, this thesis adopts Wattis, Curran and Roger's approach as a foundation for the current research to build upon.

Wattis, Curran and Rogers' (2017) definition of spirituality may not be absolute, however its benefits lie in its open-ended approach, and its accessibility to both Public Health Practitioners and non healthcare individuals. However, one of the criticisms of this description of spirituality is that it is not necessarily a definition that can be easily operationalised or measured for research purposes (Wattis, Curran and Rogers, 2017). In addition, although a concept analysis of spirituality was completed at the beginning of this thesis, Wattis, Curran and Rogers' (2017) definition was more applicable to these findings and wider Public Health practice, because they drew on a wide range of literature and focused more on healthcare than a singular concept analysis of spirituality. Wattis, Curran and Roger's definition remains particularly useful for Public Health because of the timeliness of its recognition of people's individuality and adaptability to the appropriate setting and situation, favouring a person-centred approach.

5.2.10 Summary

In line with the current literature, this section noted the difficulty of defining spirituality. It evaluated the six themes of spirituality found in this research (connection, self, beliefs, values, deeper awareness and experiences), consistent with existing research. This thesis offers further support and draws on Wattis, Curran and Rogers' (2017) definition of spirituality, with an attempt to describe spirituality in the context of Public Health in the UK. This definition of spirituality is flexible and acknowledges individuality. For Public Health practitioners, this definition can be useful because it encompasses a wide variety of themes of spirituality and can be applied to various contexts.

5.3 Spiritual practices

The findings of this study show that, for some people, it was reported that spirituality is not about the practice but more about belief, as just over half of those who identified as spiritual engaged in spiritual practices; yet those who did not engage in spiritual practices still perceived spirituality to have a positive effect on their health. This may be linked to the literature, which suggests that SBNR people are 'salad bar spiritualists', meaning they are picking the aspects of spirituality they like (Mercadante, 2020). Therefore, a focus on the belief aspect is just as important as the spiritual practices, if not more so. This could be further explored and acknowledged when describing spirituality.

The next section presents three new insights of this study in relation to spiritual practices: first, 5.3.1 discusses the spiritual practices in which SBNR participants in this study engaged; second, 5.3.2 presents where participants engaged in spiritual practices; third, 5.3.3 demonstrates how they perceived these spiritual practices to affect their health. These new insights help build on the existing arguments about the perceived benefits of spiritual practices to people's health.

5.3.1 Types of practices

This study provided a unique insight into some of the spiritual practices that are engaged in by some people in the UK who identify as both healthy and SBNR. The most popular activities reported were meditation, prayer, yoga, walking in nature, going to a spiritual building, healing, reading, and spending time with others. Although these activities could be considered spiritual, they could also be seen as secularised practices. For example, it could be argued that meditation and yoga particularly have become secularised in recent years (Brown, 2019).

Importantly, research shows that holding a spiritual belief was reported to enhance these practices. Wachholtz and Pargament (2005), for instance, found that mindfulness practitioners who identify as spiritual, as opposed to non-spiritual, benefit more fully from mindfulness practice. In addition,

Büssing et al. (2012) posited that people had an experience of oneness during or after a yoga class and felt more 'in touch with the divine or something spiritual' after a class than people in the control groups. This leads researchers to believe that yoga practice enhances transformational processes, including spiritual states. In this light, the current study supports these findings, namely, that spirituality is strengthened through these particular practices, because even if the practices are nonreligious, they still have a spiritual element. This is further demonstrated through this study: participants who did not engage in spiritual practices still reported benefits from holding a spiritual belief. For Public Health, these findings provide more insight into some of the spiritual practices people are engaging within the UK.

As discussed in sections 2.6.4.3 and 2.14.4.2 of the literature review, spiritual practices such as participating in organisational and non-organisational spiritual activities were used as measures of spirituality due to the fact that they are easily quantifiable (Baker, Stroope and Walker, 2018; Hosseini, Chaurasia and Oremus, 2019; Willard and Norenzayan, 2017). Indeed, Reave's (2005) research shows that the more objectively quantifiable spiritual practices can be linked to measurable outcomes, the stronger the empirical basis for further theoretical development is. For example, the reflective practice of meditation has been studied extensively, but other reflective practices such as prayer, contemplation, and spiritual reading are virtually untouched due to being less objectifiable concepts (Reave, 2005). Swinton and Mowat (2016) add to this by stating that deeper individual and unique experiences are difficult to quantify objectively (rather than how many times a day they engage in a particular activity, which can be quantified), and thus are sometimes missed. Consequently, research predominantly concentrates on spiritual practices as they are easier to measure. In this thesis, this was demonstrated to be true, as the spiritual practices of the participants were easy to identify.

5.3.2 Spiritual environments

This study has provided insight into some places where people in the UK engage in spiritual activities. Predominantly, existing research on spiritual practices has tended to take place in wilderness areas (Ashley, 2007; Fredrickson and Anderson, 1999; Heintzman, 2007; Stringer and McAvoy, 1992; White and Hendee, 2000), forests (Williams and Harvey, 2001), or the outdoors in general (Allcock, 2003). However, the current study revealed slightly different results, as the most popular locations were people's homes, and within spiritual or religious places. In addition, 'outdoors' was also noted in this study, supported by Allcock's (2003) findings that some people practise their spirituality outside. Research suggests that with contemporary advances in technology, people are engaging with spiritual practices via the internet (Bormann et al., 2017; Rosmarin et al., 2010), and some practices such as yoga, meditation, and prayer can now be delivered online.

5.3.3 Spiritual practices and health

The current research revealed that most questionnaire participants identified themselves as spiritual, but just over half (n=417) engaged with spiritual practices. Nevertheless, even those who did not engage in spiritual activities still reported a positive relationship to health. This might be because, rather than engaging with other or social spiritual activities, people are 'retreating inwards' and 'focusing on themselves' (Wuthnow, 2003, p.307). This last point was also reflected in participants' definitions of spirituality within the current study. Nevertheless, the findings of this thesis confirm that many of the participants reported health benefits regardless of whether they engaged in spiritual practices or not. Arguably, those who engage in spiritual practice(s) may report to be healthier because they are more active and have a sense of better mental health (Koenig, 2012; Oman, 2018).

Some literature has predominantly examined the health benefits of single spiritual practices, such as meditation, prayer, and yoga. For example, Galante et al. (2014) explored the effect of kindness-based meditation on health and wellbeing, Masters and Spielman's (2007) produced a meta-analysis on the relationship between prayer and health, and Ross et al. (2013) conducted a national survey with yoga practitioners about the benefits of yoga in relation to people's mental and physical health. This current study, by contrast, found that many participants engaged in multiple spiritual activities, with numerous reported benefits. Therefore, it could be argued that the current body of literature overlooks this approach of multi-activity engagement in spiritual practice, an avenue worthy of further attention.

In addition to this, for some of the participants in this study spiritual practices were perceived to benefit their health by increasing their happiness levels, providing relief from current illness, reducing stress and anxiety, and even changing their physiology. Previous research broadly supports these findings. For example, as Oman (2018, p.48) suggests, engagement in spirituality or religion may 'contribute to favourable health impacts'. This research helps build the case further that many of these activities can be viewed by some as a means of personal self-growth, enabling the person completing said activities to feel good about themselves. However, a negative effect of spiritual practices on people's health also has to be acknowledged, which is discussed in more depth in section 5.7.8.

5.4 How spirituality is perceived to influence different dimensions of people`s health

As stated at the beginning of this thesis, the main aim of Public Health is to prevent disease, prolong life and protect health through the organised efforts of society (Scriven, 2017; WHO, 2021). As a result, the next section is divided into two parts: first, a discussion of how spirituality is perceived to affect different dimensions of people's health (sections 5.4.1-5.4.6); followed by negative or nil effects of

spirituality on health (sections 5.4.7-5.4.8); whilst situating the findings of this study within the literature. The next sections relate to Public Health because it identifies people's needs, which can complement 'person-centred care' from a Public Health perspective. It joins this study's findings with existing literature, with the aim of furthering the literature surrounding current understandings of the relationship between Public Health and individuals, and their experiences of spirituality and health.

In each of the following sections, the study discusses the link between the themes of spirituality and dimensions of health. For example, for physical health, the themes of spirituality that were reported to influence people's physical health were 'self-improvement', 'values', and a sense of 'connection'. The specific dimensions of physical health it was reported to encourage people to choose were healthy lifestyle behaviours, such as exercising, looking after the physical body, and having healthier diets. This is consistent across all the dimensions of health.

Multiple interconnections between spiritual themes and the other dimensions of health

It is important to acknowledge that the seven dimensions of health are distinct. However, at times, they presented multiple interconnections between spiritual themes and the other dimensions of health, which were perceived to influence people's health. For example, there is an overlap between emotional and mental health, which was also true for social and societal health. To illustrate this point, interview participant 1 commented in the emotional health section: '*My mental health has been greatly improved by me doing spiritual prayer regularly. I do it every night before bed'* (male, 67+, retired spiritualist facilitator). Yet there are also references to mental health. This was similarly true for social health. One of the questionnaire participants in the social health section commented: '*It gives you emotional strength and self-esteem to have the confidence to meet new people.*' The term 'emotional strength' and 'self-esteem' could also be seen as part of the emotional health dimension. This needs to be acknowledged when interpreting these findings. It also illustrates the overlap and interconnection between the dimensions of health; this is, however, true for holistic health generally (Naidoo and Wills, 2016; Scriven, 2017). This is also a potential trend found in the current literature (although perhaps not acknowledged). For example, Mercadante (2020) discusses the spiritual struggles of those who identify as SBNR and the effects on both their mental and emotional health, regarding the difficulty of knowing one's place in relation to others, whether with family or on a societal level. This could be seen as influencing their social and societal dimension of health; however, the research is not framed in that way.

5.4.1 Physical health

One of the findings of this study was that spirituality, particularly the themes of '*self-improvement'*, *'values'* and a sense of '*connection*' (as themes of spirituality), was reported to encourage people to choose healthy lifestyle behaviours, such as exercising*,* looking after the physical body*,* and having healthier diets. Similarly, the qualitative questionnaire and interview results found that people's perceived spiritual beliefs enabled some participants to *'make positive lifestyle choices'*, thus further supporting the notion of spirituality being a reported asset to health. This is supported by existing literature from religious studies (Koenig, King and Carson, 2012), although this study shows insight for people who identify as SBNR in the UK.

This current study helps make the case further that some participants reported spirituality as a preventative measure against ill-health. The quantitative questionnaire data found that 67.3% (n=491) of the participants thought spirituality substantially impacted illness prevention. Spirituality as a form of illness prevention was also supported in the literature, as Büssing, Ostermann and Matthiessen (2005) found that those with strong faiths believed they were more resilient to life-changing diseases. However, the qualitative data in this study expands on this, by showing that thinking specifically about the 'self' within the parameters of spirituality encouraged participants to look after themselves. Spiritual beliefs acted as a method for participants to cope with stress or anxiety and helped some participants to '*feel in control'*.

This study found that perceived spirituality improved people's physical health, particularly in relation to their diet. For example, 55.7% (n=407) of the questionnaire participants perceived that there was a strong relationship between their diet and values. The qualitative data showed that some people believed that spiritual beliefs could affect the diet they chose to follow, which had a secondary effect on their overall physical health. For example, *'I have now become vegetarian, for moral reasons as I care about the food I put in my mouth. This also helped me to lose weight and be so much healthier'*. However, Tan, Chan, and Reidpath (2014) conducted a study in the USA, which found that living in more spiritual and religious neighbourhoods might play a role in influencing the adoption of a healthier diet. They found is it possible that people who consider spirituality or religion important will also follow the dietary guidelines of their religion, and the long-term dietary practice required by certain religions might, in turn, influence the outcomes of diet-related diseases (Tan, Chan, and Reidpath, 2014). For example, compared with Non-Adventists, Adventists enjoyed a longer lifespan, lower risks of cancers and coronary heart diseases, lower all-cause and cancer mortality, and lower cardiovascular mortality. Therefore, spirituality has the potential to have an effect on people's ways of consuming food, which could benefit their physical health.

It does need to be acknowledged in the quantitative data that less than half (46.9%; n=430) of the questionnaire participants stated that spirituality positively influenced their 'overall physical fitness', which could be linked to a lack of engagement in spiritual practices. When explored in the qualitative data, most of the interview participants reported a link between their physical fitness and health, for example, '*My spiritual beliefs have improved my physical fitness as it makes me want to look after myself!'*. For those who find spirituality beneficial, research demonstrates that physically fit people can maintain their optimum weight and are less prone to cardiac problems and other health problems (Centre for Disease Control and Prevention, 2017), improving aspects of people's overall physical health. It is beyond the remit of this thesis to explore this avenue; however, this relationship is deserved of further critical attention.

In conclusion to this section, the research of this study builds upon and expands the existing body of literature in the field of Public Health regarding how spirituality was reported in some cases to promote physical health. More specifically, the data gathered in this thesis centres on new critical pathways into how motivation, improvement of overall general physical health, and ethical choices are cemented through individual spiritual belief patterns, leading to some participants perceiving themselves to be physically healthier.

5.4.2 Mental health

Spirituality was shown to be beneficial to many of the participants' mental health in this study; this is not surprising, as this is an area in which there is a great deal of research, as noted in the literature review (for example, Cornah, 2006; Dein, Cook, and Koenig, 2012; Park and Slattery, 2013). Many people in this study perceived that spirituality had a positive effect on their mental health; they believed that this was due to spirituality giving them the tools to cope with stress. These findings were supported by previous research, which found that spiritual (and religious) factors can provide positive guidelines for living and social support (Koenig, King and Carson, 2012; Park and Slattery, 2013). Both the existing literature and this current research show how spirituality can be an asset to promoting people's mental health as, for some people, spirituality was reported to be a support mechanism in times of difficulty.

According to Public Health Matters (2015), a government review, there is clear evidence that social factors have powerful influences on physical and mental health. Using community 'insider' knowledge, building social networks, having a safe place to live, and a sense of belonging can help break down the barriers that prevent many people from having good mental health. Existing literature explores how

good communication is essential for people to feel listened to, valued, and not isolated (Spurr, 2017), positing that spirituality might remove some of these barriers, resulting in a powerful positive influence on many areas of health. In this research, the quantitative data showed that a high percentage (71.2%; n=521) of the questionnaire participants thought spirituality helped to improve their communication with others. The qualitative data in this study echoed this; it was reported that spirituality helped many participants connect with others within their communities (this could also be linked to social and societal health).

In relation to mental health dimension, this study argues that spirituality enabled some participants to think more clearly and more likely to positively evaluate situations. Some participants felt that spirituality created time for thinking and provided '*space for reflection'*. Similarly, previous research shows that, in some cases, meditation can reverse people's stress response (Selhub, 2007). Therefore, it is not surprising that spirituality and spiritual practices helped some participants to think clearly and concentrate, made them feel in control of their lives, and enabled them to have a perspective on life. These factors can contribute to being a positive determinant of people's health.

To enhance this even further, this study found that some participants perceive that spiritual beliefs and practices help them to engage with *'others within the community'* and look at situations in a '*more positive light*'. This could be seen as a 'cross over' of several dimensions of health, especially as a '*feeling a sense of belonging to a community'* was very important for some participants. All this research further alluded to the fact that spirituality can be perceived as a way of building a community and furthering societal engagement. Community engagement creates a sense of belonging in the local community (Mental Health Foundation, 2018; NHS, 2017; Stickley and Hui, 2012), and can contribute to a potential improvement in mental, social, and societal dimensions of health.

This study identified that spirituality was associated with '*resilience*' and '*having the strength to cope in difficult situations'*. It was also associated with the ability to solve problems, and develop coping strategies. Participants described the notion of feeling that they had to go through traumatic life experiences in order to develop spiritually, mentally, and emotionally. Even though the context is different, existing research has also discussed the role of spirituality in helping to build resilience for trauma survivors, which may advance our understanding of human adaptation in these specific cases (Farley, 2007; Peres et al., 2007). Kelly and Eddie (2020) and Mercadante (2020) found that spiritual struggles can also lead to confusion, despair, and negative coping such as addiction, workaholism, or depression. All these factors need to be considered when examining how spirituality is perceived to be beneficial to an individual's mental health.

Another discovery of this research was that some perceived spirituality as a good '*treatment for poor mental health'*. The findings further identified it as a coping mechanism when experiencing complex life challenges. Previous literature supports the notion that holding a belief gives people a way to cope when life becomes difficult (Koenig, 2001; Koenig and Cohen, 2002; Koenig, King and Carson, 2012; Park and Slattery, 2013). This belief may relate to the attainment of a fulfilling life, as it has been endorsed in the field of positive psychology (Seligman and Csikszentmihalyi, 2014).

The existing literature demonstrates sound foundations for the following argument: spirituality is good for mental health. The current study identified that for some participants, spirituality helped them to cope in times of difficulty, and some perceived spirituality to benefit poor mental health (which was also reflected in the literature). These findings offer insight into the notion of spirituality being a potential asset to some people's mental health, as the findings conclude that spirituality can help people communicate and engage with others; thus, in turn, promoting community engagement.

5.4.3 Emotional health

The findings of this research have shown that, for a majority of the participants, spirituality promoted their emotional health as it helped make them happier. Within Public Health literature, one definition of happiness was 'the overall appreciation of one's life-as-a-whole, in short, how much one likes the life one lives' (Veenhoven, 2008, p.449). In addition, Miller (2008) defined happiness as 'a state of being optimistic, amiable and untroubled by worries or doubts.' Within this research, 'happiness' was used as a term by many of the participants. In the quantitative data, it was a generally agreed consensus (80%) that spirituality had a reported positive impact on people's 'joy of life'. Some of the relevant literature demonstrated that a combination of perceptions of meaning in life and daily spiritual experiences were significant predictors of subjective happiness (Cavazos Vela et al., 2015). This was strongly echoed in this study: happiness and joy were themes that frequently arose when participants engaged in their spiritual practices, such as 'walking the dog' or 'praying', which were perceived to be happy activities.

This notion of spirituality, that it can make some people happy, is discussed in other research, which showed that having a spiritual belief gave some people guidelines to live by, thus providing a sense of coherent meaning to their lives. For example, it could help them feel as if they had found their purpose in this world (Emmons, 2005; George, Ellison and Larson, 2002). This was supported by additional literature, which suggests spirituality was an essential theme in the meaning of life (Purdy and Dupey, 2005), happiness (Abdel-Khalek and Lester, 2017), and overall life satisfaction (Cavazos Vela et al., 2015), illuminating the perceived positive attributes of spirituality on some people's health.

There was a strong consensus (75.4% n=552) that spiritual 'beliefs' positively influenced the participants' self-esteem. The qualitative data provided an explanation that this is due to people feeling '*inner peace'* and greater confidence. The findings identified spirituality as a *'buffer'* against stress which is a significant aspect of the spiritual 'belief' theme. In part, this is echoed by existing literature stating that spirituality can play a central role in reconstructing a 'sense of self' and 'recovery' (Mohr and Huguelet, 2004). Previous research has also found that positive emotional (and mental) health is fostered by helping people develop strengths, or buffers, against psychopathologies; such buffers clearly include the intentional pursuit of positive emotions and experiences, such as joy or happiness (Shoshani and Steinmetz, 2014). The current study supports these findings and provides evidence in favour of this being an area that, with more research, could be further explained in light of spirituality having an overwhelmingly positive effect on both emotional and mental health.

In the quantitative data, spirituality had the most significant positive effect on emotional and spiritual health. This was also supported by the existing literature, as most of the previous studies have noted the positive effect of spirituality on poor mental and emotional health (Baetz et al., 2004; Bonelli and Koenig, 2013; Carothers et al., 2005; Cornah, 2006). However, as this study demonstrates, it does not mean spirituality does not affect other dimensions of health, only that mental and emotional health has been given the most attention to date.

These insights in relation to Public Health are valuable because spirituality was shown to have a positive effect on the emotional dimensions of participants' health. This research illustrates how spirituality can complement people's health by providing them with a sense of happiness and improving their self-esteem. This study reflects previous findings in the literature and develops this area of research further by bringing together all the literature with regard to emotional health. It can be argued that spirituality could be beneficial for this dimension of health and should be further explored within Public Health practice.

5.4.4 Social health

In the current study, spirituality was reported to positively affect the participants' social health by making them think more deeply about their connections with others (64.5% n=469). This was supported by the questionnaire's qualitative findings, as spirituality was shown to '*bring people together'*, thus enabling deeper connections. This socialisation could be viewed as being part of what has been termed 'human nature' (Bain, Kashima and Haslam, 2006; Baumeister, 2005; Maslow, 1954), specifically, the notion that humans are social beings and feel the need to engage and connect with others (Rutherford, 2019). Consequently, this study, along with the existing literature, appear to reinforce the positive nature of the relationship between spirituality and social health.

Having the 'right' community was also shown to be useful for some of the participants in this study. Previous research also found that having the 'right' community was beneficial when people were recovering from illness or feeling stressed, and served as a preventive measure (Gilchrist, Bowles and Wetherell, 2010). This study's findings make the case that spirituality was beneficial to some people's health as it is a mechanism to offer networks of assistance, thus supporting the extant research in this field.

Another aspect that the qualitative data expands on was engagement with others in the community. The participants wanted to be part of the community, but they felt disconnected, perhaps even isolated, although some participants did choose to isolate themselves. Three interviewees (3, 4, 5) identified the need to be part of '*local communities'*. Stickley and Hui's (2012) research shows that people gain social, psychological, and occupational benefits from this. Therefore, this study adds to the current research in Public Health, by focusing on the specific importance of the relationship between an individual's own spiritual beliefs and their connection to, and feeling a part of, their community. This could be seen as an overlap with societal health.

The findings of this particular section further reinforced by a finding of this study, namely the benefit of social support; a '*feeling of connection with others'* was shown to be a *'preventive measure against stress'*. This was also echoed in the literature (Cornah, 2006; King et al., 2013; Park and Slattery, 2013). Research demonstrated that spiritual and religious beliefs enabled people to have better coping mechanisms when feeling these mental strains (Cornah, 2006; Koenig, 2014; Park and Slattery, 2013). This further illuminates the point that spirituality was considered a preventive measure against stress for some people by offering some sense of support, which is an area that could be developed for the future in Public Health Practice.

Crucially, the current study has provided new insight into the ways in which spirituality influences participants' relationships. This is evidenced by 63.8% (n=266) of the questionnaire participants noting that spirituality positively influenced their relationship with their families. The qualitative results suggested that this was due to *'bringing them closer together'*, thus further supporting the 'connection' theme of spirituality. Having healthy relationships and forming strong bonds with others is beneficial in several ways, such as helping people communicate their worries and feel they have the support of others in times of need (Bengtson, 2001; Gove, Hughes and Style, 1983). It was clear that, for some people in this study, this notion of strong social support and a sense of purpose was vital for their health. Therefore, a finding that emerged from both this study and the literature was that spirituality could provide an overall improvement in relationships within families.

This was also shown to be true for people in romantic relationships, as 59.7% (n=392) of the questionnaire participants who had partners perceived that spirituality had positively influenced their relationship, due to being able to relate to and communicate with others better. This study found that, generally, their partners held a similar belief. Therefore, they enjoyed a stronger bond and engaged in spiritual practices together. This did not occur in the original literature findings; however, research shows that healthy relationships and connections make a person feel secure, happy, loved, respected, and free to be themselves (Johnson, 2011). This could be linked to some people not needing to socialise with others, due to having this strong bond. Overall, they feel happier, which is related to improved self-esteem (Baumeister et al., 2011; Mongrain, Chin and Shapira, 2011).

Sharing the same spiritual beliefs and practices helps some people maintain and foster friendships. This is further supported by the quantitative data, which demonstrates that a positive relationship with spirituality helped some people to '*maintain their friendship*'. Previous research confirms that social relationships are fundamental to fulfilling core human needs, such as the need to belong (Baumeister and Leary, 1995; Cacioppo and Patrick, 2008; Cacioppo, Hawkley and Thisted, 2010). Research suggests that people who are more socially connected have better psychological wellbeing, are more mentally and physically robust, and even live longer than less socially connected people (Cacioppo, Hawkley, and Thisted, 2010; Holt-Lunstad, Smith, and Layton, 2010; House, Landis, and Umberson, 1988). Thus, this continues to build on the argument that spirituality was good for some people as it enabled them to have a shared interest in others.

One of the findings of this study was that some of the participants were potentially better at making new friends, rather than maintaining long-term friendships, as there was a 10% decrease in comparison to maintaining long-term friendships. Research by Rutherford (2019) suggests this could be due to an element of conflict between the personal self and the community. This is perhaps not necessarily a negative, as it could be a means of looking after the self and having higher self-esteem (Branden, 2011; Neff, 2011; Wylie, 1989). Therefore, it could be that some people who identify as SBNR focus more on the 'self' and less on other people. The notion is, then, that 'spirituality' acts simultaneously as both a filter and a magnet, as people drift towards friends and communities who share similar resonating themes of spirituality as themselves (Fuller, 2001). Thus, for the field of Public Health, the need to be aware of this relationship was also supported by the previous literature.

It is important to note that the results found that a minority of participants (4.2%; n=31) felt that spirituality was harmful to their social health, as it made people focus inwardly on themselves and less on others. Some people's spiritual beliefs meant they did not feel the need to engage with others because their spiritual practices are solitary and/or they prefer to mix with people with similar beliefs.

Similarly, Michaelson et al. (2019, p.17) argue that the 'development of a sense of self can be vital to positive mental health' because it can give some people a sense of autonomy. The notion is that individuals should be allowed to make decisions for themselves and that others should respect those decisions unless the decision involves harming someone else (Herring, 2014). Therefore, potential health disadvantages to spirituality also need to be acknowledged.

To further make this argument, the 'connection' element of spirituality provided some people with community engagement; as also echoed in the quantitative data, 57.7% (n=422) of participants identified it as having a positive effect. A connection was essential to people's social health because being part of a community was identified as a fundamental need (Mental Health Foundation, 2018). Alternatively, there is research to suggest that individual's communities could reject others because of their beliefs. For example, they could be ostracized for not drinking alcohol, leading to individuals feeling unable to engage in certain social activities, being disappointed by their beliefs and feeling demoralised when life does not go according to their plans (Koenig, King and Carson, 2012). The notions of connection and community engagement may need to be further considered in order to enable people to engage more fully with as wide a variety of social and spiritual activities as possible.

This study has shown that, for some people, spirituality was perceived to have no effect on social health, but for others, spirituality was shown as an effective means to connect people. This, in turn, was seen as improving people's relationships with their family, friends, and partners. The participants who engaged in spiritual practices also described engaging with people who helped some of them to thrive. This research shows that spirituality complements social health for some people, because it brings together a new awareness of the relationship between social health and spirituality. Therefore, this study builds upon previous literature surrounding spirituality, specifically works that focus on the 'inclusion of spirituality within national Public Health' that 'may provide a new lens through which to examine fundamental questions about people`s collective values, principles, purpose and meaning' (Egan and Timmins, 2019, p.55).

5.4.5 Societal health

Over half of the participants (n=422; 57.7%) thought that spirituality had positively influenced their engagement within their community (similar findings were also noted for social health). The qualitative questionnaire data revealed the importance of people feeling connected; this was illustrated by their comments, for example, 'sense of belonging', *'I engage more with people in the community and thus make more friends*.'; *'I love being with people now! I feel a sense of belonging'*. This feeling of a sense of 'connection' is also echoed by other researchers, stating that it is vital for

people's health because it provides social support and a sense of community (Seppala, Rossomando and Doty, 2013; Wilkinson and Marmot, 2003). These findings help to develop further the argument that spirituality is a way to provide '*networks of assistance'*, which in turn act as a method to build healthy communities.

The literature review has demonstrated that it is particularly important for people to have a strong sense of belonging so that other health needs can be fulfilled (Baumeister, 2005; Maslow, 1962). The findings of this thesis support these findings, as a majority (n=509; 69.8%) of the questionnaire participants perceived that spirituality had positively affected their 'sense of belonging'. The results propose that this could be due to them holding a belief that gave them a feeling of purpose and meaning in their life. Additionally, a lack of belonging can have adverse effects on some people, causing them to become disaffected and disengaged within their home lives, work, and communities (Wanless, 2004). In turn, this could lead to a lack of involvement in activities and a lack of purpose that can be detrimental to people's self-esteem and sense of belonging (Aldwin et al., 2014; Stickley and Hui, 2012). It is important to acknowledge that just over a quarter (n=196; 26.8%) of the participants implied it did not affect them, and a small number of participants (n=25; 3.4%) stated that it actually harmed their sense of belonging. When expanded upon in the qualitative results, one participant stated that: *'I feel more confident in my own beliefs which not only gives me a sense of belonging but less of a need to belong with others or in society*'. However, although the participant felt less of a desire to belong to others, this was not harmful to their health and can be interpreted positively. In this light, Rutherford (2019) posited that it is good to look after yourself before others. Thus, this notion must be addressed when discussing spirituality within Public Health, so that practitioners might be aware and sensitive to people's needs.

An interesting finding in the societal health section of this thesis suggested that a great deal of participants potentially did not feel that they needed to connect with others and that they were more individualistic, self-contained, or focused on themselves. One of the reasons this could be the case may be linked to the neoliberal consumerist society and people's recognition of their own needs (Crossman, 2019; Gauther, 2017). Another explanation of why this could be the case centres around how people connect with others, such as via social media or feeling more content within themselves (Taylor, 2002). This point is something that needs to be considered when ascertaining information on how spirituality might be reported to influence people's health.

For Public Health, these new insights help to deepen knowledge on the relationship between spirituality and societal health. The overall findings and literature help to illuminate that this is perhaps

an area that could be investigated further to improve relationships between some people and build healthier communities. Similar findings were also reflected in social health.

5.4.6 Spiritual health

Through the literature review, it has become evident that spiritual health tends to be one of the most neglected areas of healthcare (Chidarikire, 2012; Miller and Thoresen, 2003; Oman, 2018; Oman and Thoresen, 2007; Swinton, 2001). In light of this, the findings of this thesis centres upon this current gap regarding the importance and relevance of spirituality to Public Health. There was a strong relationship between spirituality and the feeling of being connected with the world in this study (n=562; 77%), as spirituality was reported to make some people feel grounded and to serve as a method of '*coping with the stresses of life'*. In the spiritual health section, some participants also reported '*having a sense of wellbeing'*, which made them feel more connected and less isolated, thus positively contributing to their spiritual health.

Several interview and questionnaire participants discussed feeling that there is '*hope in oneself and in the world'*. This led to the feeling of a stable and consistent foundation, even during times when everything else in people's lives seemed to be a source of instability. Previous research by Koenig (2012) and Maslow (1962) shows that having needs met and having a sense of purpose motivates people to make healthier choices. Consequently, this study's results suggest that having hope and a sense of purpose is fundamental to motivating and enabling some people to make positive life choices that are beneficial to all aspects of their health. The results showed that, in many cases, holding a form of belief can enhance participants' lives. This fed into spirituality becoming a vital part of people's broader beliefs and consequently, for some, it was perceived as having a practical impact on their spiritual health. Oman (2018) and Spencer (2012) argue that, for others, believing or committing to a spiritual belief or activity, such as meditation or yoga, meant people improved at these activities. The results also indicated that when a person is fully immersed in a spiritual activity they tend to be in a '*happy state of mind'*. Therefore, this finding supports the strong notion that spiritual beliefs enhance a person's life, and there is research demonstrating that this full engagement is healthy (Oman, 2018). Nevertheless, Spencer (2012) proposes that the development of spirituality is generally recognised as requiring some sort of practice or discipline in order to make 'progress'. However, the current study's findings suggest that progress was not required for people to experience some benefit.

Another finding was that a '*sense of purpose'* and '*understanding of a person's place in the world*' helped provide people with a sense of vitality, motivation, and resilience. There is some research to suggest that human beings crave purpose and suffer serious psychological difficulties when it is absent

(Peck, 2002; Taylor, 2013). Thus, it can be argued that having a sense of purpose is a fundamental theme of a fulfilling life, and many of the participants of this thesis believed that spirituality gave them this sense of purpose. This notion is supported by the wider literature, which has explored how spirituality can be seen as promoting people's spiritual health by providing a set of ethical rules to follow (Thoresen, 1999; Thoresen and Harris, 2002).

It should also be noted that a quarter of the questionnaire participants (n=160; 22%) thought spirituality had no effect on their spiritual health. However, the opposite might have been expected, especially if the participants viewed themselves as spiritual. This could be explained perhaps by the fact that although some participants held a spiritual belief, they did not actually perceive it to affect their spiritual health; it could be due to how the question was phrased (or their understanding of spiritual health) (Saris and Gallhofer, 2014), or it could be simply they had never been asked, therefore had never thought about it.

These findings enhance and support the argument that further research into spirituality might complement the field of Public Health and healthcare more broadly. Spirituality is clearly important for many people, and more attention could be given to this area of spiritual health. This thesis puts forward the argument that spiritual beliefs should be considered more within Public Health; the results of this study, supported by previous research, provide a good theoretical and evidential basis for complementing Public Health practice.

5.4.7 Negative effects of spirituality on health

Only a minority of the participants reported that spirituality was seen as detrimental to their health. In the quantitative data, there were a few areas where a minority of the participants identified spirituality as having a negative impact, such as on sleep (n=53; 7.2%), and stress levels (n=60; 8.1%). Participants highlighted the negative effects of focusing too much on the self in the qualitative data. Hay (2000) suggests this could lead to the issue of these practices becoming a 'means of individualistic self-justification of narcissism masked as spirituality'. Although not found in this study, it is worth noting that some spiritual activities relating to spiritual beliefs may be significantly detrimental to health. This can include people taking actions that they cite as being motivated by their beliefs, such as paedophilia, diabetic patients choosing to 'fast', parents giving nutritionally unbalanced diets to children, as well as the action of refusing immunisations and vaccinations (Koenig, King and Carson, 2012). However, these can be seen as extreme practices, and even though these individuals could perceive themselves as spiritual and healthy, this could result in poor health outcomes. There is also the issue of cultural competence, and the need to be culturally sensitive while also protecting the

health of the individual. Therefore, Public Health practitioners need to be aware of the possible negative effects of spirituality.

One of the restrictions of this study is that there is a limited number of negative comments within the qualitative data; therefore, there was difficulty in providing plausible explanations as to why this was the case, although existing literature has been drawn on to provide some rationale. The literature review also identified some of the aspects of being SBNR that can be damaging to health due to spiritual struggles and stigma (Baker, Stroope and Walker, 2018; Mercadante, 2020). The results from this research indicated that there were issues with a sense of self. There can also be a significant problem with disappointment in relation to the kind of 'manifesting' spirituality promoted by spiritual traditions like 'The Secret' or 'Cosmic Ordering'. However, the participants in this research did not mention these types of spirituality. Again, this could be linked to the current neoliberal consumerist type of spirituality discussed at the beginning of this thesis (section 1.3), which could perhaps have been explored further in this research.

Although not examined in this thesis, there is a growing body of literature on contemporary spirituality movements becoming sites for developing conspiracy theories such as Anti-vaxxers or Qanon. Anti-vaxxers are people who believe that vaccinations are a human rights violation (Berman, 2020). Hotez (2020) claim that Qanon is a disproven far-right conspiracy theory alleging that a cabal of Satanic, cannibalistic paedophiles operate a global child sex trafficking ring and conspire against former President Donald Trump during his term in office. These movements could be seen as detrimental to people's health, as they could encourage people not to listen to medical advice, such as not having medical vaccinations, or engage in unhealthy behaviours such as rioting and harming others. Ashton (2021) suggests that, although founded in the USA, there is a growing number of Anti-vaxxers in the UK. This could be linked to some people's spiritual beliefs and ideologies (Ashton, 2021), and should be taken into account when thinking critically about how spirituality can be incorporated into Public Health based on an awareness and sensitivity of the various beliefs people hold.

5.4.8 No relationship between spirituality and health

Some participants believed that spirituality and spiritual practices did not influence their health. There were areas of health in which spirituality was shown not to have much influence, such as *'concentration'* and '*safety*', which appeared in both the quantitative and qualitative results. Only a few studies have been published which reveal no correlations between spirituality and health (Dew et al., 2008). This also suggests that not all reported effects on health may be inherently religious or spiritual, as social and cultural factors may have an impact (Williams and Sternthal, 2007). However,

this research suggests that spirituality was reported to be part of many people's health; it provides core beliefs, values, and a foundation for living.

5.5 Demographic factors

Within this study, there were some variations in the participant's demographics. From a methodological point of view, more women (27.6%) than men participated in the questionnaire study; this could be for several reasons, such as more women identifying themselves as spiritual (Wilkie, 2015) or men and women expressing their spirituality differently (Rich, 2012). A further reason may be that women are more likely to participate in online questionnaires than men (Curtin, Presser and Singer, 2000; Moore and Tarnai, 2002; Singer, van Hoewyk and Maher, 2000). Although discussed in the context of religion, more women may engage in spirituality due to the patterns of roles for men and women in society. Trzebiatowska and Bruce (2012) and Zunkerman (2014) propose that women tend to be expected to take up roles as caregivers and nurturers, raising children and tending to the sick and elderly, while men tend to be exempt from such roles. This, again, could make religion more appealing to women than men (Trzebiatowska and Bruce, 2012; Zunkerman, 2014), and could be one plausible explanation for these findings in a UK spiritual context. Furthermore, a slightly higher number of men engaged in spiritual practices (n=6.3%), and participants' sex did not seem to be a factor that influenced the relationship between their different dimensions of health and spirituality.

Specifically, the research found that only 33% of those aged 18–30 engaged in spiritual practices. Parsons (2018) implies that this could be due to spirituality being a new 'trend' with which people can identify. It may be easier for people to identify themselves as spiritual rather than to say that they are not religious (Carrette and King, 2005; Ecklund and Di, 2018; Parsons, 2018). There is also research suggesting that younger people are more likely to participate in online questionnaires than older people (Goyder, 1986; Moore and Tarnai, 2002). This was found to be true in the current study, as there was a large response rate among younger people in the questionnaire study. The questionnaire might have also appealed more to the younger generation due to the SBNR movement being perceived as relatively modern (Parsons, 2018). In relation to the participants' ages, within the younger age group (18–30), the majority of participants indicated there was a positive relationship between spirituality and their health. To a degree, these results are supported by previous research on spirituality and adolescence. For instance, one study conducted with a sample of university students showed that spirituality was a coping factor that helped participants manage distress and that it contributed positively to their psychological health (Burris et al., 2009). Another study by Sax, Asti, Korn and Mahoney (1999, in Lippman and Keith, 2006) found that spirituality was 'essential' and 'very important' to 43% of first-year college students.

The current study found that most of the participants over the age of 30 reported a stronger positive effect of spirituality and their different dimensions of health; this may indicate that people engage with more spiritual practices as they become older. Existing research has demonstrated that, as they get older, people are more likely to consider their own mortality and engage in more spiritual activities to understand their own belief system (Corr, Corr and Doka, 2018; Mercadante, 2014). This may lead to an increase in people identifying as SBNR in the UK, as more young people try to work out what they believe; thus, effects on health vary across age groups.

The participants in this study were from a wide range of occupations, areas, and ages, thus highlighting a diverse range of people engaging in spirituality and spiritual practices. One contributory factor that might be worth further investigation is the relationship between income and spirituality; the quantitative data on income demonstrated that the greater income participants had, the more they engaged in spiritual activities. Thus, it could be proposed that those who had more income were more likely to be able to participate in more 'expensive' spiritual activities, such as going to retreats. This study did not have the scope to fully examine the links between income (or more broadly social status) and spirituality. Yet, interestingly, the limited existing literature on income and spirituality suggested that those on lower incomes had higher rates of spirituality (Gill, Minton and Myers, 2010; Zavala et al., 2009), as well as spiritual struggles (Krause, Pargament and Ironson, 2017). However, Willard and Norenzayan (2017) noted that income was not different for the non-religious and the SBNR population. Nevertheless, it also needs to be acknowledged that a high number of participants chose not to answer the questions around income; this might be because some participants find questions about employment and income to be intrusive (Davern et al., 2005). Dancey, Reidy and Rowe (2012) and Saks and Allsop (2012) suggest that some participants might have chosen not to answer the questions because they did not think this information was relevant. Others may have lost interest when they came to this part of the questionnaire (Dancey, Reidy and Rowe, 2012; Saks and Allsop, 2012). Further exploration of quantitative data in this study regarding demographic factors may have clarified some of the issues raised.

5.6 The purpose of SHEM and its potential contribution to Public Health

The development of SHEM (discussed in section 4.9) is my unique contribution to the current body of knowledge in the field of Public Health. SHEM has two main purposes. Firstly, section 5.6.1 provides a single visual description of the reported relationships between spirituality and health. Secondly, section 5.6.2 presents how SHEM could potentially complement existing Public Health practice. The limitations of SHEM are discussed in sections 4.9.1 and 5.8.6.

5.6.1 A visual explanation of the reported relationship between spirituality and health (SHEM)

Research has shown that visual explanations are useful tools in representing a process, enhancing comprehension, and explaining ideas and concepts (Bobek and Tversky, 2016; Fiorella and Kuhlmann, 2020). Visual explanations can depict ideas that can be challenging to put into language (Bobek and Tversky, 2016), and make concepts easy to understand, which can help reinforce learning (Hendricks et al., 2016). One of the benefits of SHEM is that it visually illustrates the reported relationships explored in this research.

The purpose of this map (and this research more broadly) is to provide an insight into how spirituality can potentially influence these different health dimensions; SHEM literally 'maps out' the themes that emerged from the current study. These themes, as I have explored, were generally supported by current literature (such as the findings of Koenig (2012), Braam and Koenig (2019) and Weaver et al. (2003)) thus drawing the whole body of this research together in a comprehensive format which can help Public Health practice in adopting a more holistic view of individual health needs.

Particularly in Public Health literature, models, maps, and images tend to be utilised as a simple way of illustrating meaning (Nutbeam, 2000; Sørensen et al., 2012). The map presented uses a simple and clear image to help Public Health practitioners illustrate the reported relationship between spirituality and peoples' health. SHEM is presented using the six themes (connection, self, belief, values, deeper awareness, and experiences). Through the six themes, SHEM attempts to clarify the construct of spirituality based on sound empirical foundations. The overriding strength of SHEM is that it is derived from observations of real-life peoples' voices and experiences, and clearly and quickly communicates the relationships to a relevant professional audience who are not experts in the fields of religion or spirituality.

The way in which SHEM is presented helps the reader; indeed, research has demonstrated the benefits of using arrows or lines in visual explanations (Bobek and Tversky, 2016). SHEM uses lines to illustrate the potential relationships and to show potential connections, a useful technique as arrows or lines are widely produced and understood as representing a range of different forces, as well as showing changes that have occurred over time (Bobek and Tversky, 2016; Tversky et al., 2007).

5.6.1.1 SHEM in comparison to previous models

Although not discussed in the original review, the literature was re-examined to allow analyses of other models that explored the relationship between spirituality and health. The examination of these models in relation to SHEM helped situate the findings. Three models were selected due to their relevance to this research:

• Aldwin et al. (2014): Differential Impact of Religiousness and Spirituality on Pathways to Morbidity and Mortality.

• Koenig, King and Carson (2012): Theoretical Model of Causal Pathways for Physical Health.

• Koenig, King and Carson (2012): Theoretical Model of Causal Pathways for Physical Health for Secular Humanism.

The three models' illustrations are presented in Appendix 13. Included in the Appendix is an analysis and brief explanation of how each model was developed. These three specific models are not only well known in this field but also relevant to this research, as they have some similarities to SHEM. There are aspects in these models that are consistent with SHEM, such as coping, social connections, and a sense of meaning; however, none of these models seems to include all dimensions of health. The models by Aldwin et al. (2014), Koenig, King, and Carson (2012) only focus on mental and physical health and combine religion and spirituality. On the other hand, SHEM can be seen as more inclusive of the dimensions of health. The focus of the aforementioned three models was predominantly religion rather than spirituality, whereas SHEM focuses specifically on spirituality. This is more in line with current societal cultures in the UK (discussed in section 1.3), and is also reflected within emerging health literature, for example Damiano et al. (2021), Chirico (2021) and Rosales and Agena (2021). SHEM was developed in the UK specifically for use in the field of Public Health, whereas all the other models were developed in the USA, which (as noted in both of the literature reviews) can be seen as culturally different to the UK, and therefore not representative of a UK population. However, further research is required as, to date, none of the models discussed has been tested in practice. All these illustrations provide valuable insight into some of the underlying mechanisms that could be influential.

5.6.2 How SHEM can complement Public Health practice

As discussed at the beginning of this thesis, Egan and Timmins (2019) argued that Public Health practitioners in the UK struggle to discuss spirituality within their area of work. This may be due to it being the missing determinant of health, a criticism supported by researchers such as Oman (2018) and Swinton (2012). SHEM could be viewed as potential theoretical guidance for Public Health practitioners, used to complement spirituality within Public Health practice. This may help develop and improve competent spiritual practice in healthcare. It could also be viewed as a valuable tool for teaching and future research.

SHEM as presented could be seen to support the application of these core philosophies and values in what is described elsewhere as a 'person centred' approach to Public Health practice (discussed in section 1.2.2). The challenge for practitioners using conceptual frameworks and models is to translate

abstract constructs into everyday practice. SHEM is derived from the perspectives of people in the UK and, by using their theoretical constructs, it avoids the use of ambiguous and complex terminology, as an attempt to raise awareness of the potential relationship. A further strength of SHEM is its dynamic nature, with each dimension within the map interlinked and interdependent.

To summarise, this thesis contributes to the field of Public Health by adding greater insight and support for a deeper understanding of how spirituality can potentially influence peoples' health in the UK. SHEM contributes as an important emerging illustrative tool, as it culminates the findings alongside the provision of a simple explanation. Hence, it builds on existing literature and enables conceptual insight that one day could be implemented into practice.

5.7 Limitations of this research

The limitations of this PhD study have been discussed throughout this thesis, especially in the methods chapter. It will also be discussed in the next six sections: 5.7.1 measurement of people's perceptions; 5.7.2 questionnaire design; 5.7.3 validated spiritual tools; 5.7.4 bias within the data; 5.7.5 sample; and finally, 5.7.6 SHEM. These limitations need to be considered when interpreting the findings of this study. In future research on spirituality and health, the following limitations, which will be outlined in detail, should be considered.

5.7.1 Measurement of people's perceptions

In terms of measurement, this study only examined perceptions of spirituality and did not measure any physiological impacts, such as measuring the participants' blood pressure when engaging in spiritual practices. Hence, it is impossible to determine the physiological effect of spirituality on health from this study. There is also the issue of grouping together and comparing a massively varied subject matter in terms of the participants' spiritual practices, such as tarot card reading and yoga. These varied activities could have very different implications on health. However, the focus of this study was not on a wide range of individual activities, but rather on the broader concept of 'spirituality'. A person's spiritual activities may also change throughout their life and depend on the time of year. There was also no assessment of the specificity of the types of spirituality identified by participants. Although this is beyond the scope of this thesis, this is an important point to make.

Regarding objective measures, other ways of measuring spirituality could be considered; for example, one could measure spirituality and health as separate variables and do a correlational analysis between the two. Likewise, a comparative study including those who identify with other religious belief systems would be beneficial in order to ascertain which has the most significant effect on

people's health. A potential issue with this research was that it only asked the participants to provide a 'snapshot' of their perceptions of spirituality regarding their health, which may not factor in the varied determinants of people's health, such as age, gender, housing, and environment (Dahlgren and Whitehead, 2006).

5.7.2 Questionnaire design

The design of the questionnaire itself also has limitations; first, it only explores how spirituality affects health and not the other way around. It is also possible that some questions could have been asked more concisely, and the questionnaire could have been shortened in order to make it more likely that participants fully completed all questions. There are also issues around language and definitions in the questionnaire; for example, I did not make a distinction between certain words, such as mental and emotional health. In the interviews, further exploration of to what extent spirituality affects health could also have been asked in more detail.

Another issue that arose, which could partly be due to the design of this study and my own bias, was that I did not explore what 'health' meant to the participants, for example 'free from disease and infirmity' or a state of 'unwellness'. The way in which the data was collected focused on how spirituality was reported to affect health, not how health was reported to affect spirituality. It could also be argued that additional questions could be asked; for example, not asking the participants if 'they considered themselves religious?',' 'how do you define religion?' This also includes using different and validated measures of health. Potentially, a limitation of this research is that the participants were not asked if they had a religious belief, which would have enabled further insight to make sure that those who identified as SBNR were specifically targeted.

Within the data collection and the results of this study, health was divided into dimensions to make it easier to assess what effect spirituality had on each dimension. However, it was difficult to know to what extent each dimension of health affects another. For example, an aspect of one's physical health, such as having a physical disability, might impact one's social health due to an inability to access resources. Some research has argued that spirituality is 'inseparable from physical, social and physiological care because it is indistinguishable from the wholeness of care' (Bradshaw, 1994, p.282). The design and analysis of this study were influenced by my personal and professional experience; which 'although reflexively explored can create bias and also may have led to me selecting data for analysis which fitted with my own preconceptions' (Rogers, 2016, p.309). Pilot testing the questionnaire would also have been useful to fully test the research instruments.

Another limitation of this study is that the validity of the questionnaire could have been enhanced, as this study used face validity, which is the weakest form of validity because it only refers to the transparency or relevance of a test (Holden, 2010; Oluwatayo, 2012). Despite this, using an online questionnaire was still considered the best approach to conduct data for this research as it is still valid. However, if this study was to be repeated, a potential improvement could be by paying more attention to validity.

With some of the questionnaire participants' responses there was difficulty understanding why the participants thought spirituality had a positive or negative effect on health, as this was not specifically commented on. For example, there was an interesting finding in the societal health section that suggested that more participants potentially did not feel that they needed to connect with others and that they were more individualistic, self-contained, or focused on themselves in their lives, yet none of the participants gave a rationale as to why this was the case. Therefore, more in-depth and further exploration could have been given at times.

5.7.3 Validated spiritual tools

A further criticism of this research lies in the non-utilisation of validated questionnaires or measures. The benefit of using a validated tool is that they have already been tested; therefore, they can be seen as more rigorous, and more likely to measure the right thing (Monod et al., 2011; Selman et al., 2011). Not using a validated spiritual tool or a previously validated survey means this research might not be reliable or rigorous (Monod et al., 2011; Selman et al., 2011). Measurement plays a vital role in the reproducibility and replicability of research findings, and the confidence researchers may have in their findings to derive theoretical conclusions from them. Gremigi (2020) argues that a lack of validated spiritual tools may lead to questionable theoretical conclusions and reduce the replicability of results. Although this is a criticism of this study, there are also issues surrounding the lack of consistency within the individual tools concerning the variables being measured; for example, some of the measures include measures of religious affiliation, or lack of religious affiliation, and/or participation in spiritual practices, while others did not (Gijsberts et al., 2011; Lewis, 2008; Monod et al., 2011; Selman et al., 2011). Therefore, this was exploratory research, and validated tools were consequently not used on the specific population that formed the focus of this study.

5.7.4 Bias within the data

A potential limitation of this study is that those who responded in the quantitative questionnaire data that 'spirituality '*has no effect at all'* or has '*a negative effect'* did not tend to leave a comment in the

qualitative section. For example, a quarter of the questionnaire participants indicated that spirituality had no effect on their physical health. This made it challenging to present and discuss this aspect of the data, which could be perceived as a bias. This was also true of interview data, as few negative comments were presented. Previous literature can give an indication as to why the participants responded in particular ways; however, this aspect could still be seen as a bias of this research. Another limitation is the fact that inferential statistics were not explored; this may have helped to provide further insight into the relationship between spirituality and certain demographics. However, this was not the focus of this thesis and can be examined at a later date if required.

5.7.5 Sample

Due to the collection methods, some of the participants who took part could perhaps be considered to be more spiritual than the 'average' person, simply because they chose to engage with the questionnaire. Moreover, some of the interviewed participants could be considered more spiritual than the average person because their employment was related to spirituality or involved spiritual practice. This potential bias may mean that those who are SBNR are likely to rate spiritual effects much more highly than those who do not consider themselves to be spiritual. Those who are not on social media are also not included in this study, which could be seen as a limitation. If this research were going to be replicated, this aspect would need to be considered.

In this study, the participants self-reported that they are healthy. However, again, this study did not go into detail about participants' definitions of a healthy diet or a healthy sleep pattern. To the participants, a 'healthy' diet is subjective: it might consist of a high amount of sugar and the consumption of large quantities of alcohol. As a result, from a Public Health perspective, the participants might not be as healthy as they reported in this study, or may have under or overplayed their health status. One of the reasons that an online questionnaire was used for this research was so that participants did not have to give personal details, yet this also makes it difficult to know how truthful the participants were being, or whether their perceptions matched up with more objective Public Health measures or indicators of health. Furthermore, it is unclear to what extent these results could be influenced by social desirability bias; for example, people with spiritual beliefs may want to justify and rationalise their choices. In addition, this study attempted to focus only on members of the UK population who are SBNR, yet how they defined SBNR was not explored, as this is a highly subjective term.

5.7.6 SHEM

There are also limitations to the SHEM (as also discussed in section 4.9.1); aspects are potentially missing from this illustration, which was not picked up in this study or the two literature reviews. Some of these factors in the map may be due to the generality of people's lives and may not necessarily be attributed to spirituality; there may be some elements that cannot be conceptualised or measured. Some people do not believe that spirituality affects their health; therefore, this SHEM might not be relevant to them. This map also does not consider the context and setting. There is difficulty being explicit about the links as there was overlap between the dimensions of health (such as emotional and mental health) and themes of spirituality. It is also challenging to separate the variables that potentially impact health; including those that have not been identified in this research. SHEM is only an initial attempt to conceptually illustrate the reported relationship between spirituality and dimensions of health. Despite this, it is still might be helpful for Public Health practitioners to provide insight into the potentially reported relationship. This could benefit from further exploration.

5.8 Chapter summary

This discussion chapter has built upon existing research, and further provided insight into the relationship between participants' perceptions of their health and their spiritual beliefs and practices. Crucially, it has sought to bring new awareness of how the application of spirituality can be potentially used in the field of Public Health through SHEM, providing a framework through which to understand how people report spirituality affects and influences health. To further this research, it would be prudent to collect information about spirituality from those who identified as both healthy and SBNR.

In relation to spiritual practices, this study provided several new insights. The most popular activities related to spirituality were meditation, prayer, yoga, walking in nature, going to a spiritual place(s), healing, reading, and spending time with others. The most popular reported locations in which participants engage in spiritual practices were at home, outside, and in spiritual or religious places, a finding which partly goes against previous literature. Spiritual practices were perceived to have some benefits on participants' health, for example, by making them happy and improving other areas of their health. The study also found that engaging in more than one practice can provide more benefits than only engaging in one spiritual activity, as reported by the participants.

The findings of this research and existing literature revealed that spiritual beliefs may provide motivation and a form of social support for some people; this support could be a valuable source of self-esteem, information, companionship, and practical help that enable people to cope with stress and adverse life events. For some people, it was reported that spirituality helps them to increase their

physical activity by giving them a purpose to go outside, improve their mood, and be more active during their spiritual practices. However, spirituality was shown to improve some people's emotional and mental health by giving them the coping strategies, resilience, and tools (such as optimism, routine, and social support) to cope with everyday life. There is evidence that, for some people, spirituality can make them more sociable, because they go out to engage with spiritual activities and meet other people in the process. For a few, spirituality makes them less sociable. The research suggests this was because engaging with other people caused them stress; by contrast, focusing on the self is more important. The demographic factors revealed there was some disparity between the participants' answers, particularly in relation to gender, age, and income, and these differences require further investigation.

The chapter has argued that SHEM can be a useful tool for illustrating to Public Health practitioners (and others interested in the field) how spirituality can potentially contribute towards people's holistic health; especially for those who identify as SBNR, which appears to be a growing population (Fuller, 2001; Mercadante, 2014; Parsons, 2018). Public Health practitioners should also be mindful that spirituality does not have an effect on some people, and a few may even perceive it to be harmful. It must be recognised that this is only an exploratory study, so limitations must be noted. However, the evidence presented helps to make a convincing case that some people do perceive spirituality to impact their health. Thus, this could be considered part of person-centred care and contribute to new knowledge in this field.

Finally, this chapter has also highlighted the limitations of this research; including measuring people's perceptions, questionnaire design, validated spiritual tools, bias in the data, the sample size, and SHEM illustration. Despite this, SHEM might be the first step in encouraging health practitioners to discuss people's spirituality, as part of existing health enquiries. This research further reinforces that spirituality made some people happy, content and joyful. Spirituality was reported to have a positive impact on health; it has relevance in the care of ill patients and could also be a method to keep healthy people healthier for longer.

Chapter Six

Conclusion

6.0 Introduction

The following concluding chapter assembles the findings of this thesis, offering recommendations for future research. The chapter is divided into five sections. Following this, section 6.1 presents the conclusions of the investigation, highlighting the main findings of the study. Section 6.2 discusses the contribution of this thesis to new knowledge, and 6.3 posits a proposed dissemination strategy of this thesis. The next section, 6.4, provides recommendations for future research, whilst 6.5 offers recommendations for policy and practice. Finally, section 6.6 summarises this final chapter.

6.1 Conclusion

This thesis proposed to help inform Public Health practitioners by providing insight into how spirituality could facilitate health benefits in the UK population. Indeed, the role of Public Health is to improve people's health (Acheson, 1988; Mancuso, 2008; Nutbeam, 1998; WHO, 2019). In light of this focus, the thesis has endeavoured to understand better the reported relationship between people's spiritual beliefs and their health through rigorous critical research, with the goal of building upon and providing new insights into the role of spirituality in Public Health Practice in the UK. This study has sought to add to the significant progress that many other health professions (such as nursing, social work and psychology) have made in addressing the growing need to include spirituality within healthcare, through the delivery of its own distinctive contribution to the field of spirituality and health, from the perspective of Public Health.

This contribution has been achieved by meeting the criteria of the thesis objectives. Firstly, objective one resulted in gathering participants who identified as being healthy, and those who did not identify as healthy were then excluded from the rest of the data set. It must be noted that if this study were to be repeated, it would be advantageous to explore people's understanding of health, for example, how they define it, and how this understanding and definition changes over a person's lifespan (particularly in relation to spirituality).

For objective two, the study examined the definition of spirituality from the participants' perspective. It was found that spirituality was made up of six themes: connection, self, belief, values, deeper awareness and experiences. Upon further exploration of how the participants described spirituality, the research concluded that the themes reported by the participants in this study also mirrored those of Wattis, Curran and Rogers (2016) definition of spirituality. The thesis utilised this definition, as its

flexible and multifaceted approach (healthcare professionals can tailor this definition to apply to individualistic care (MacKenzie, 2017)) was complementary to current healthcare research, whilst also incorporating the themes set out above. For Public Health practitioners in particular, this definition is useful because it encompasses a wide variety of attributes and can be applied to various settings, whilst its application can also broaden current understandings of how spirituality is viewed by those who consider themselves SBNR.

When exploring the participants' spiritual practices (objective three), only half of the participants stated that they engaged in spiritual activities. Of those participants who did, the spiritual practices were categorised into eight themes: meditation, prayer, yoga, walking in nature, going to a spiritual building, healing, reading, and spending time with others. Along with the interview participants, these findings provide insight into the particularities of how people in the UK engage in spiritual activities. The participants not only engaged in a wide range of spiritual practices, but also locations, including at home, outside, in spiritual places, and some even stated that they practised spirituality 'everywhere'. However, it should be noted that this could vary over a person's lifespan and is dependent on access to resources and the time of year (Edelman and Kudzma, 2021). For some of the participants, spiritual practices were reported to be beneficial to their health due to feeling better connected, calmer, and less stressed. Some participants also reported that it made them feel joyful, content, and at peace.

Objective four explored the reported relationship between the participants' spiritual beliefs and health. For the first time, participants were recruited from the UK population (with a specific focus on those who identify as both healthy and SBNR) and examined people's perceptions of how spirituality affects their health. Whilst spirituality did not affect the health of all participants, and a small number believed that spirituality could be detrimental to their health, in both the quantitative and qualitative results, the study demonstrated that spirituality was reported to positively influence people's health, especially their emotional, mental, and spiritual health. Although further research is required, SHEM is a useful way to help illustrate how spirituality can complement some people`s health.

Objective five considered whether demographic factors impact spirituality and participants' health. Gender did not seem to be a factor that affected the overall mean scores, as there were only small variations between the dimensions of health and spirituality. Slightly more (12.2%) men than women engaged in spiritual practices, though overall, more women than men filled in the questionnaire. This may have been the result of a greater number of women participating due to them being more interested in spirituality, or because they were more likely to engage with online questionnaires (Curtin, Presser and Singer, 2000; Moore and Tarnai, 2002; Singer, Van Hoewyk and Maher, 2000). In

regard to age, only 33.3% of those aged 18-30 declared engagement in spiritual practices. Generally, the questionnaire participants over the age of 30 perceived a more positive relationship between spirituality and dimensions of health. The results demonstrated that there was not a great variation between education and spiritual practices, though a majority of the participants had A levels or more. Those who participated in the questionnaire came from various professions, including a police officer, cook, and health care assistant. Nevertheless, more research is needed to explore further demographic factors in relation to spirituality and health.

6.2 Contribution to new knowledge

This investigation has offered three main contributions to knowledge: firstly, it provides new insight into a topic that has not been scrutinised this way before; secondly, it utilises an innovative methodology (mixed methods), which complements the Public Health sphere, and thirdly, it offers original arguments for how this research could help complement existing Public Health practice.

The role of spirituality has been historically under-researched within Public Health practice. This thesis aimed to rectify this dearth, producing two literature reviews (and links the literature defining spirituality with a published concept analysis, which was an earlier contribution to this work) and an empirical study exploring spirituality within Public Health. It focused on people who reported to be both healthy and SBNR in the UK, a focus not previously carried out before in research, using a pragmatic mixed methods approach (whereas previous studies mostly examined either qualitative or quantitative data), and a new illustration (SHEM) was created, demonstrating some of the ways in which people perceive spirituality to affect their health.

This study is the first of its kind to explore spirituality and its relations to Public Health in the UK. It has attempted to fill some of the gaps in the existing literature; for example, it focused on people who identified themselves as 'healthy' rather than unhealthy, and those who identify as SBNR within the UK, discussing spirituality in the context of Public Health. This nuanced approach has also combined a range of previous literature findings and the findings of this research to argue that spirituality has an important role to play within Public Health. Furthermore, this study has provided the framework through which a number of research avenues to be conducted in future critical work, by identifying some of the ways in which spirituality can be incorporated into Public Health practice.

As previously mentioned, the thesis contributes an innovative mixed methods methodology not yet explored in the UK context, utilising two forms of knowledge, nomothetic and ideographic, thus successfully and succinctly bringing a range of new insights together, contributing to a paradigm shift

in Public Health that values both forms of knowledge. The studies that have previously been conducted in this area have been either qualitative or quantitative. The thesis gathered a large amount of data collected from a large sample, which in part helped to give greater confidence in this study's findings (Bryman, 2016). The utilisation of these methods means this research has been able to identify areas that may be important to determine what spirituality is and to describe its perceived effect on people's health. For Public Health practitioners (also discussed in section 6.5), these findings offer innovative insights into how spirituality is described according to a sample of UK participants who reported to be both SBNR and healthy. To date, most of the current empirical research has been carried out in the USA, which carries different contexts.

This research is imperative for the long-term future of Public Health. With additional research, it could help complement Public Health concerns, such as the rise in loneliness and mental health issues (Mental Health First Aid Course, 2019; Stuckler et al., 2017). Indeed, further research is required in terms of helping people with their health, especially ways that are within an individual's control, because of the constraints on NHS budgets and wider Public Health sector budgets. With more robust research, this could well be an area worthy of further investigation.

Furthermore, this research (as well as being supported by previous literature) may help some Public Health practitioners understand and think about spirituality in their own practice more. Ensuring that spirituality is understood, explored, and integrated into practice is one way of providing truly holistic care (Rogers, 2016). This study wishes to support and echo this recommendation. It is hoped that, in the long term (with more research), this study may benefit not only some Public Health practitioners but also the wider population, as they might reflect on their own spiritual needs and values in life and practice.

6.3 Dissemination strategy

Disseminating the findings and outcomes of research can be challenging and requires a strategy to ensure a broad spectrum of outputs so that the study achieves maximum readership and influence (Green and Thorogood, 2014; Jones, 2016). The study presented in this thesis has implications for Public Health practice in the following areas, including Public Health researchers, practitioners, and wider Public Health professionals. Table 47 presents an outline of the proposed publications and conference papers following the submission of this thesis.

Table 47: Proposed publications and conference papers following submission of this thesis

Proposed publication	**Intended format**	**Target audience**
PhD Thesis.	Thesis	Deposit the final thesis in the CCCU repository and British Library Ethos service.
Executive summary of the findings.	Summary document	The participants who participated in the study. General social media.
A systematised review of systematic reviews: 'Is there an association between adults` spiritual beliefs and Public Health outcomes?'	Journal article	Health researchers and health practitioners.
A systematised review: 'Is there an association between adults who identify as SBNR and Public Health outcomes?'	Journal article	Health researchers and health practitioners.
Public Health and spirituality in the context of contemporary 21st century healthcare practice Conference presentation.	Conference	Conference presentation British Association for the Study of Spirituality Conference 2023/2024.
Using a mixed method study design to explore spirituality in Public Health practice.	Journal article	Health researchers and health practitioners.
Utilising spirituality in Public Health using the SHEM Model: A 21st century model for guiding practice.	Journal article	Health researchers and health practitioners.

6.4 Recommendations for future research

As this research was an exploratory study, it has left many questions that still need to be answered. For example, how do different beliefs such as Atheism, Christianity, Buddhism, and different spiritual practices affect health in various ways (particularly in the UK)? This is also reflected in the DH Annual Report of the End-of-Life Care Strategy (2011), which recognises that there is still significant work to do on meeting people's spiritual needs in relation to their particular beliefs. As outlined previously, it would also be prudent to explore further what the participants mean by health and how health was perceived to affect their spirituality.

Further analysis of this data (including inferential statistics) could be conducted to answer some of the additional questions raised by this study, such as whether there are correlations between demographic characteristics, spiritual beliefs, and health. However, these questions were beyond the remit of this study, yet could be further explored in future research by collecting additional data and utilising validated spiritual tools. A longitudinal study to observe the themes of spirituality on people's health and other potential influencing variables over a long period could be incredibly valuable, as well as further research looking at the relationship between spirituality and health over a person's lifespan, particularly in an SBNR population. This would provide further clarity on the impact that spirituality has on health.

This study has provided insights into how some people perceive the essential themes of spirituality (illustrated in the SHEM map), which may help produce some reported health benefits in terms of disease prevention, recovery from illness, and coping with stress. However, this relationship has the potential for further investigation. Oman (2018) recommends that raising awareness of how people's spiritual beliefs affect health is fundamental for future research, practice, and education within Public Health, and is a critical perspective that is fundamental to the importance of raising awareness of this topic in further investigations.

The voice of Public Health practitioners and their view on how spirituality affects health was absent from this study, and this is a perspective that would be worthy of further in-depth exploration. This is also supported by Egan and Timmins' (2019), and Oman' (2018) research, which highlights the importance of a more comprehensive exploration of Public Health practitioners' views of spirituality and spiritual care. The next stage of inquiry might include an additional investigation of the themes identified in this research. In the longer term, with more research, it is hoped that SHEM could be further developed and, perhaps one day, tested in Public Health education and practice by Public Health practitioners.

In brief, these recommendations could provide more insight into the reported relationship between spirituality and people's health. Potential research might benefit from exploring this topic from different perspectives, including comparing the impact on health depending on people's belief systems and the health practitioner's perspective. Additional investigations of the themes found in this study and additional analysis of this study's data (including inferential statistics) could be further investigated. Finally, a longitudinal study capturing people's beliefs over a lifespan may provide a more in-depth level of insight.

6.5 Recommendations for future policy and practice

This research has the potential to help inform future policy and practice by demonstrating that spiritual beliefs play a significant part in contributing to improved health for some people in the UK. Although further research is required, the relationship between spirituality and healthcare could be reflected more within current Public Health policy and practice for positive purposes, in a similar vein to the ways in which the relationship between the importance of people's beliefs and its effect on health has been addressed in other bodies of literature, including nursing, medicine, and social care (Oman, 2018).

Another implication that needs to be considered within Public Health policy and practice is changing the language used in Public Health practice, research, and education. Moving away from the term 'religion' to 'spirituality' to incorporate a wide range of beliefs makes these fields far more inclusive to a range of people's beliefs (NHS Scotland, 2002; NHS Scotland, 2009). There are many indications of this starting to happen in policy, such as 'Culture, Spirituality and Religion: Migrant Health Guide (2017). However, it would be useful to have a more consistent approach across all government policies, guidance, and other organisations that support people's health. This also includes consistency with the definition of spirituality.

For Public Health practice, this thesis has argued that SHEM could potentially provide information on the reported relationship between spirituality and health. SHEM (although only in its infancy) is a relatively simple way of illustrating how, for some people, their spiritual beliefs were reported to affect their health. Even though more research is required, this study helps to inform Public Health practitioners of the broader themes which may be crucial to some people's health, such as connection, self, beliefs, values, deeper awareness, and experiences.

Finally, it could be suggested that spirituality should be reflected considerably more in Public Health policy and practice to help create healthy individuals and communities in the long term (Oman, 2018). Using more inclusive language when talking about people's spiritual beliefs instead of religious ones

might reflect current society's belief systems. SHEM may help to inform some Public Health practitioners about what spirituality is and how it can be successfully implemented in practice.

6.6 Chapter summary

In conclusion, this study has contributed new knowledge to the existing and growing body of research on spirituality. Its particular contribution lies in its nuanced exploration of the role of spirituality in the field of Public Health in the UK, an avenue not previously explored (from this specific perspective). The thesis has demonstrated that, for many people, spirituality was reported to be an essential contribution to their health. If further incorporated into health practices, the research of this thesis can benefit people's holistic needs; therefore, Public Health providers could consider ways to incorporate spirituality into wider healthcare guidance, policy, and practice.

I believe that this thesis has real-world potential to influence people's lives beyond practice, as it has helped to shape my understanding of the world, with spirituality playing an integral part in my life, work and psyche for many years. I have learned a great deal about spirituality and its fundamental reported relationship to people's health, and I hope this research is part of laying the theoretical and practical groundwork for spirituality to be further incorporated within Public Health. Appendix 14 contains a written reflective practice on my final thoughts on my thesis.

This research has helped to evidenced the need for spirituality to be considered within Public Health and healthcare in the broader sense, contributing to the existing field by further paving the way for spirituality to be considered more holistically within Public Health in the UK; consequently, it further contributes to evidence-based practice and person-centred care.

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Appendices

Appendix 1

Full list of references of the authors cited in Table Two

Author	**Full reference***
Stoll (1989, p. 6)	Stoll, R. (1989) The Essence of Spirituality 1989. In: Carson, V.B. (Ed.), Spiritual Dimensions of Nursing Practice. WB Saunders Company, Philadelphia (Chapters 14–23).
Murray and Zentner (1989, p. 259)	Murray, R.B. and Zentner, J. (1985) *Nursing concepts for health promotion.* London: Prentice-Hall.
Males and Boswell (1990, p. 35)	Males, J. and Boswell, C. (1990) 'Spiritual needs of people with a mental handicap,' *Nursing Standard,* 4 (48), pp.35-37.
Reed (1992, p. 350)	Reed, P. (1992) 'An emerging paradigm for the investigation of spirituality in nursing.' *Research in nursing and health,* 15(5), pp.349-357.
Tanyi (2002, p. 506)	Tanyi, R. (2002) 'Towards clarification of the meaning of spirituality.' *Journal of advanced nursing,* 39(5), pp.500-509.

* References ascertained from McSherry, W. and Cash, K. (2004) 'The language of spirituality: an emerging taxonomy.' *International journal of nursing studies,* 41(2), pp. 151-161.

Appendix 2

List of systematic reviews excluded from this study systematised literature review

Reference	Reason for exclusion
Berry, D. (2005) 'Methodological pitfalls in the study of religiosity and spirituality.' *Western journal of nursing research*, *27*(5), pp.628-647.	Not a systematic review
Boudreaux, E., O'Hea, E. and Chasuk, R. (2002) 'Spiritual role in healing. An alternative way of thinking.' *Primary care*, *29*(2), pp.439-54.	Not a systematic review
Bowen-Reid, T. and Harrell, J. (2002) 'Racist experiences and health outcomes: An examination of spirituality as a buffer.' *Journal of Black Psychology*, *28*(1), pp.18-36.	Not a systematic review
Capon, H., O'Shea, M. and McIver, S. (2019) 'Yoga and mental health: A synthesis of qualitative findings.' *Complementary therapies in clinical practice*, *37*, pp. 122-132.	Not directly relevant
Damiano, R., Costa, L., Viana, M., Moreira-Almeida, A., Lucchetti, A. and Lucchetti, G. (2016) 'Brazilian scientific articles on "Spirituality, Religion and Health".' *Archives of Clinical Psychiatry* (São Paulo). 43(1) pp.11-6.	Not a systematic review
Draper, P. (2012) 'An integrative review of spiritual assessment: implications for nursing management.' *Journal of Nursing Management*, *20*(8), pp. 970-980.	Not a systematic review
Egan, R., Graham-DeMello, A., Ramage, S. and Keane, B. (2018) 'Spiritual care: What do cancer patients and their family members want? A co-design project.' *Journal for the Study of Spirituality*, *8*(2), pp.142-159.	Not a systematic review
Fletcher, J. (2016) *Understandings and perceptions of spirituality held by multidisciplinary professionals involved in a community-based palliative care organization: Implications for professional practice.* (Doctoral dissertation)	Dissertation
George, L., Larson, D., Koenig, H. and McCullough, M. (2000) 'Spirituality and health: What we know, what we need to know.' *Journal of social and clinical psychology,* 19(1), pp.102-116.	Book chapter
Giumbelli, E. and Toniol, R. (2017) What is spirituality for? New relations between religion, health and public spaces. In *Secularisms in a Post secular Age?* (pp. 147-167). Palgrave Macmillan, Cham.	Not a systematic review
Gullatte, M., Brawley, O., Kinney, A., Powe, B. and Mooney, K. (2010) 'Religiosity, spirituality, and cancer fatalism beliefs on delay in breast cancer diagnosis in African women.' *Journal of religion and health*, *49*(1), pp.62-72.	Not a systematic review
Harvey, I. (2005) *The role of spirituality in the self-management of chronic illness among older adults.* Doctoral dissertation, University of Pittsburgh.	Dissertation
Hills, J., Paice, J., Cameron, J. and Shott, S. (2005) 'Spirituality and distress in palliative care consultation.' *Journal of palliative medicine*, *8*(4), pp.782-788.	Not a systematic review
Janzen, K. (2012) *Extending the Spirit: A Qualitative Secondary Analysis on Nurses' Perspectives on Spirituality.* Doctoral dissertation, Trinity Western University.	Dissertation
Jim, H., Pustejovsky, J., Park, C., Danhauer, S., Sherman, A., Fitchett, G., Merluzzi, T., Munoz, A., George, L., Snyder, M. and Salsman, J. (2015) 'Religion, spirituality, and physical health in cancer patients: A meta-analysis.' *Cancer*, *121*(21), pp.3760-3768.	Not a systematic review
Kelly, J. (2017) 'Is Alcoholics Anonymous religious, spiritual, neither? Findings from 25 years of mechanisms of behaviour change research.' *Addiction*, *112*(6), pp.929-936.	Not a systematic review
Kent, B., Stroope, S., Kanaya, A., Zhang, Y., Kandula, N. and Shields, A. (2020) 'Private religion/spirituality, self-rated health, and mental health among US South Asians.' *Quality of Life Research*, *29*(2), pp.495-504.	Not a systematic review

Keshet, Y. and Simchai, D. (2014) The 'gender puzzle' of alternative medicine and holistic spirituality: A literature review. *Social Science and Medicine*, *113*, pp.-86.	Not directly relevant
Koenig, H. (2001) 'Religion and medicine IV: religion, physical health, and clinical implications.' *The International Journal of Psychiatry in Medicine*, *31*(3), pp. 321-336.	Focus on religion, not spirituality
Koenig, H. (2008) 'Concerns about measuring "spirituality" in research.' *The Journal of nervous and mental disease*, *196*(5), pp. 349-355.	Not a systematic review
Koenig, H. (2012) *Religion, spirituality, and health: The research and clinical implications.* ISRN Psychiatry.	Not a systematic review
Kouhdasht, R., Mahdian, M., Parmouz, M. and Moghadam, G. (2019) 'The relationship of organizational spirituality with Public Health and occupational stress.' *Journal of Pizhūhish dar dīn va salāmat*, *5*(2), p.36.	Not a systematic review
Krupski, T., Kwan, L., Fink, A., Sonn, G., Maliski, S. and Litwin, M. (2006) 'Spirituality influences health-related quality of life in men with prostate cancer.' *Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer*, *15*(2), pp. 121-131.	Not a systematic review
Leamy, M., Bird, V., Le Boutillier, C., William, J. and Slade, M. (2011) 'Conceptual framework for personal recovery in mental health: a systematic review and narrative synthesis.' *The British journal of psychiatry: the journal of mental science,* (6), pp. 445–452.	Not directly relevant
Levin, J. (2016) 'Partnerships between the faith-based and medical sectors: implications for preventive medicine and Public Health.' *Preventive medicine reports*, *4*, pp. 344-350.	Focus on religion, not spirituality
Masters, K. and Hooker, S. (2013) 'Religiousness/spirituality, cardiovascular disease, and cancer: Cultural integration for health research and intervention.' *Journal of consulting and clinical psychology*, *81*(2), p. 206.	Not a systematic review
Mercadante, L., (2020) Spiritual Struggles of Nones and 'Spiritual but Not Religious'(SBNRs). *Religions*, *11*(10), p. 513.	Not a systematic review
Miller, W. and Thoresen, C. (2003) 'Spirituality, religion, and health: An emerging research field.' *psychologist*, *58*(1), p. 24.	Not a systematic review
Musick, M., Traphagan, J., Koeing, H. and Larson, D. (2000) 'Spirituality in physical health and ageing.' *Journal of Adult Development*, *7*(2), pp. 86.	Not a systematic review
Narayanasamy, A., (1999) 'A review of spirituality as applied to nursing.' *International Journal of Nursing Studies*, *36*(2), pp. 117-125.	Not a systematic review
Natsis, E. (2016) 'A new discourse on spirituality in public education. Confronting the challenges in a post-secular society.' *International Journal of Children's Spirituality*, *21*(1), pp. 66-77.	Focus on children
O'Hara, D. (2002) 'Is there a role for prayer and spirituality in healthcare?' *Medical Clinics*, *86*(1), pp. 33-46.	Not a systematic review
Powell, L., Shahabi, L. and Thoresen, C. (2003) 'Religion and spirituality: Linkages to physical health.' *American psychologist*, *58*(1), p. 36.	Not a systematic review
Puchalski, C. (2004) 'Spirituality in health: the role of spirituality in critical care.' *Critical Care Clinics*, *20*(3), pp. 487-504.	Not a systematic review
Ratnakar, R. and Nair, S. (2012) 'A review of scientific research on spirituality.' *Business Perspectives and Research*, *1*(1), pp.1-12.	Not a systematic review
Rew, L. and Wong, Y. (2006) 'A systematic review of associations among religiosity/spirituality and adolescent health attitudes and behaviors.' *Journal of adolescent health*, *38*(4), pp. 433-442.	Focus on children

Rogers, M., Wattis, J., Stephenson, J., Khan, W. and Curran, S. (2019) 'A questionnaire-based study of attitudes to spirituality in mental health practitioners and the relevance of the concept of spiritually competent care.' *International journal of mental health nursing*, *28*(5), pp. 1165-1175.	Not a systematic review
Roudsari, R., Allan, H. and Smith, P. (2007) 'Looking at infertility through the lens of religion and spirituality: a review of the literature.' *Human Fertility*, *10*(3), pp. 141-149.	Not directly relevant
Schwalm, F., Zandavalli, R., de Castro Filho, E. and Lucchetti, G. (2021) 'Is there a relationship between spirituality/religiosity and resilience? A systematic review and meta-analysis of observational studies.' *Journal of health psychology,* p.1359105320984537.	Not directly relevant
Seeman, T., Dubin, L. and Seeman, M. (2003) 'Religiosity/spirituality and health: a critical review of the evidence for biological pathways.' *Americans psychologist*, *58*(1), p.53.	Not a systematic review
Sinclair, S., Pereira, J. and Raffin, S. (2006) 'A thematic review of the spirituality literature within palliative care.' *Journal of palliative medicine*, *9*(2), pp. 464-479.	Not a systematic review
Snider, A. and McPhedran, S. (2014) 'Religiosity, spirituality, mental health, and mental health treatment outcomes in Australia: A systematic literature review.' *Mental Health, Religion and Culture*, *17*(6), pp. 568-581.	Focus on religion, not spirituality
Surbone, A. and Baider, L. (2010) 'The spiritual dimension of cancer care.' *Critical reviews in oncology/haematology*, *73*(3), pp. 228-235.	Not directly relevant
Tomkins, A., Duff, J., Fitzgibbon, A., Karam, A., Mills, E.J., Munnings, K., Smith, S., Seshadri, S.R., Steinberg, A., Vitillo, R. and Yugi, P. (2015) 'Controversies in faith and healthcare.' *The Lancet*, *386*(10005), pp. 1776-1785.	Not directly relevant
Townsend, M., Kladder, V., Ayele, H. and Mulligan, T. (2002) 'Systematic review of clinical trials examining the effects of religion on health.' *Southern medical journal*, *95*(12), pp. 1429-1435.	Not spirituality focused
Wilfred, M. (2006) 'The principal components model: a model for advancing spirituality and spiritual care within nursing and healthcare practice.' *Journal of clinical nursing*, *15*(7), pp. 905-917.	Not a systematic review
Zaza, C., Sellick, S. and Hillier, L. (2005) 'Coping with cancer: what do patients do?' *Journal of Psychosocial Oncology*, *23*(1), pp. 55-73.	Not about spirituality
Zimmer, Z., Jagger, C., Chiu, C., Ofstedal, M., Rojo, F. and Saito, Y. (2016) 'Spirituality, religiosity, ageing and health in global perspective: A review.' *SSM-population health*, *2*, pp. 373-381.	Not a systematic review
Zwingmann, C., Müller, C., Körber, J. and Murken, S. (2008) 'Religious commitment, religious coping and anxiety: a study in German patients with breast cancer.' *European Journal of Cancer Care*, *17*(4), pp. 361-370.	Focus on religion, not spirituality.

Appendix 3

Full list of references of the systematic journal articles for the systematised review.

First author	Full reference
Braam	Braam, A. and Koenig, H. (2019) 'Religion, spirituality and depression in prospective studies: A systematic review.' *Journal of affective disorders,* 257, pp.428-438.
Gijsberts	Gijsberts, M., Echteld, M., Van der Steen, J., Muller, M., Otten, R., Ribbe, M. and Deliens, L. (2011) Spirituality at the end of life: conceptualization of measurable aspects—a systematic review. *Journal of palliative medicine,* 14(7), pp.852-863.
Gonçalves	Gonçalves, J., Lucchetti, G., Menezes, P. and Vallada, H. (2017) 'Complementary religious and spiritual interventions in physical health and quality of life: A systematic review of randomized controlled clinical trials.' *PloS one,* 12(10), p.0186539.
Gordon	Gordon, B., Keogh, M., Davidson, Z., Griffiths, S., Sharma, V., Marin, D., Mayer, S. and Dangayach, N. (2018) 'Addressing spirituality during critical illness: A review of current literature.' *Journal of critical care*, 45, pp.64-81.
Hai	Hai, A., Franklin, C., Park, S., DiNitto, D. and Aurelio, N. (2019) 'The efficacy of spiritual/religious interventions for substance use problems: A systematic review and meta-analysis of randomized controlled trials.' *Drug and alcohol dependence,* 202, pp.134-148.
Hosseini	Hosseini, S., Chaurasia, A. and Oremus, M. (2019) 'The effect of religion and spirituality on cognitive function: a systematic review.' *The Gerontologist,* 59(2), p.e76-e85.
Hulett	Hulett, J. and Armer, J. (2016) 'A systematic review of spiritually based interventions and psychoneuroimmunological outcomes in breast cancer survivorship.' *Integrative Cancer Therapies,* 15(4), pp.405-423.
Lewis	Lewis, L. (2008) 'Spiritual assessment in African-Americans: A review of measures of spirituality used in health research.' *Journal of Religion and Health*, 47(4), pp. 458-475.
Liefbroer	Liefbroer, A., Olsman, E., Ganzevoort, R. and van Etten-Jamaludin, F. (2017) 'Interfaith spiritual care: a systematic review.' *Journal of religion and health,* 56(5), pp.1776-1793.
Milner	Milner, K., Crawford, P., Edgley, A., Hare-Duke, L. and Slade, M. (2020) 'The experiences of spirituality among adults with mental health difficulties: a qualitative systematic review.' *Epidemiology and psychiatric sciences*, 29.
Monod	Monod, S., Brennan, M., Rochat, E., Martin, E., Rochat, S. and Büla, C. (2011) 'Instruments measuring spirituality in clinical research: a systematic review.' *Journal of general internal medicine,* 26(11), pp.1345-1357.
Moreira	Moreira, W., Nóbrega, M., Lima, F., Lago, E. and Lima, M. (2020) 'Effects of the association between spirituality, religiosity and physical activity on health/mental health: a systematic review.' *Revista da Escola de Enfermagem da USP,* 54.
Schreiber	Schreiber, J. and Brockopp, D. (2012) 'Twenty-five years later—what do we know about religion/spirituality and psychological wellbeing among breast cancer survivors? A systematic review.' *Journal of Cancer Survivorship,* 6(1), pp.82-94.
Selman	Selman, L., Harding, R., Gysels, M., Speck, P. and Higginson, I. (2011) 'The measurement of spirituality in palliative care and the content of tools validated cross-culturally: a systematic review.' *Journal of pain and symptom management,* 41(4), pp.728-753.
Shaw	Shaw, A., Joseph, S. and Linley, P. (2005) 'Religion, spirituality, and posttraumatic growth: A systematic review.' *Mental Health, Religion and Culture,* 8(1), pp. 1-11.
Thune-Boyle	Thune-Boyle, I., Stygall, J., Keshtgar, M. and Newman, S. (2006) 'Do religious/spiritual coping strategies affect illness adjustment in patients with cancer? A systematic review of the literature.' *Social science and medicine,* 63(1), pp.151-164.
Tate	Tate, J. (2011) 'The role of spirituality in the breast cancer experiences of African women.' *Journal of Holistic Nursing,* 29(4), pp.249-255.
Wang	Wang, C., Chow, A. and Chan, C. (2017) 'The effects of life review interventions on spiritual wellbeing, psychological distress, and quality of life in patients with terminal or advanced cancer: a systematic review and meta-analysis of randomized controlled trials.' *Palliative Medicine*, 31(10), pp.883-894.

Weaver	Weaver, A., Flannelly, L., Garbarino, J., Figley, C. and Flannelly, K. (2003) 'A systematic review of research on religion and spirituality in the Journal of Traumatic Stress: 1990–1999.' *Mental Health, Religion and Culture*, 6(3), pp.215-228.

Appendix 4

List of validated spiritual tools identified within the systematised literature review

Author	Context	Validated spiritual tools identified
Gijsberts et al. (2011)	Palliative care	The Spiritual Needs Inventory (SNI); JAREL Spiritual Wellbeing Scale; Quality of Life at the End-of-Life Measure (QUAL-E); the Hospice Quality of Life Index; the Missoula it as Quality-of-Life Index; the McGill Quality of Life Questionnaire; the Good Death Inventory; Needs Assessment for Advanced Cancer Patients.
Lewis (2008)	African Americans	Spiritual Wellbeing Scale (SWBS); Index of Spiritual Experiences (INSPIRIT); JAREL Spiritual Wellbeing Scale; Spiritual Perspectives Scale (SPS); and Functional Assessment of Chronic Illness Therapy Spiritual (FACIT-Sp).
Monod et al. (2011)	Clinical research	The Spiritual Perspective Scale; The Daily Spiritual Experience Scale (DSES); Spirituality Assessment Scale; The Multidimensional Measure of Religiousness / Spirituality (MMRS); The Brief Multidimensional Measure of Religiousness / Spirituality; The Spiritual Involvement and Beliefs Scale (SIBS); The Index of Core Spiritual experience; INSPIRIT; The Spiritual Transcendence Scale; The Spiritual Health Inventory (SHI);The Royal Free Interview for Religious and Spiritual Beliefs; The Spirituality Scale; Spirituality and Spiritual Care Rating Scale; The Brief Pictorial Instruments for Assessing Spirituality; The Higher Power Relationship Scale; Orientation toward religion and spirituality index; Spirituality Self rating Scale; The Expressions of Spirituality Inventory; The Spiritual Experience Index; The Ironson-Woods; Spirituality/Religiousness Index; The Beliefs and Values Scale; The Spiritual Beliefs Questionnaire; The Spiritual Transcendence Index; The Intrinsic Spirituality Scale; The Functional Assessment of Chronic Illness Therapy - Spiritual Well Being Scale (FACIT-Sp); The Spiritual Wellbeing Scale (SWBS); WHOQOL SRPB (spirituality, religion and personal beliefs); JAREL spiritual wellbeing scale; The Spirituality Index of Well-Being (SIWB); Spiritual Coping Measures; The System of Beliefs Inventory (SBI-15);The Spiritual Strategies Scale; The Spiritual Support Scale; Spiritual Needs Measures; Spiritual Needs Inventory; The spiritual interests related to illness tool (spIRIT); The Spiritual Needs scale; The Spiritual Needs Questionnaire.
Selman et al. (2011)	Palliative care	Assessment of quality of life at the end-of-life instrument Chronic Illness Quality of Life Ladder; Functional Assessment of Chronic Illness Therapy—Palliative; Hospice Quality of Life Index-revised; Hospice Quality of Life Scale-Korean; Life Evaluation Questionnaire; McMaster Quality of Life Instrument; MVQoLI (including 15-item version and modified Ugandan version; MQOL (including Hebrew, Korean, Hong Kong, Persian, Taiwanese, and Japanese versions; Cardiff-Short Form and Malay Cardiff Short Form; WHOQOL-HIV (including Italian and Brazilian versions; WHOQOL-HIV-BREF; Skalen zur Erfassung von Lebens Qualitat bei Tumorkranken-modified version; Brief Hospice Inventory; Cancer Worries Inventory; Hope Differential-Short; Needs Assessment for Advanced Cancer Patients; Cancer Worries Inventory; Hope Differential-Short Needs Assessment for Advanced Cancer Patient; Needs at the End-of-Life Screening Tool; Problems and Needs in Palliative Care Questionnaire; QUAL-E; Palliative Care Outcome Scale; The McCanse Readiness for Death Instrument; The Patient Dignity Inventory; EMS; JAREL Spiritual Wellbeing Tool; Peace, Equanimity, and Acceptance in the Cancer Experience; Spiritual Perspective Scale; Beck Hopelessness Scale; Coping with Illness Scale; Measure of coping in HIV; Beliefs and Values Scale; I-W SR Index Short Form; Spiritual Activities Scale; Spirituality and Religion Survey; Spiritual Involvement and Beliefs Scale; Spiritual Needs Inventory; Duke Religious Index or the Duke Religion Index.

Appendix 5

Articles excluded from this study from the full-text literature review

Reference	Reason for exclusion
Bramadat, P., Coward, H. and Stajduhar, K.I. (2013) *Spirituality in hospice palliative care*. SUNY Press.	Book
Caldwell-Harris, C.L., Wilson, A.L., LoTempio, E. and Beit-Hallahmi, B., 2011. Exploring the atheist personality: Wellbeing, awe, and magical thinking in atheists, Buddhists, and Christians. *Mental Health, Religion and Culture*, *14*(7), pp.659-672.	Not relevant to Public Health
Dossett, W. (2013) 'Addiction, spirituality and 12-step programmes.' *International Social Work,* 56: pp.369–383.	Not on SBNR population
Dossett, W. and Metcalf-White, L. (2020) 'Religion, spirituality and addiction recovery: introduction.' *Implicit Religion*, *22*(2), pp.95-100.	Not an empirical review
Edie, F. (2015) 'Doubling Down on Liturgy: Inviting the "Spiritual but Not Religious" to Discover Sacramental Spirituality.' *Liturgy*, *30*(3), pp.40-47.	Opinion piece
Huss, B. (2014) 'Spirituality: The emergence of a new cultural category and its challenge to the religious and the secular.' *Journal of Contemporary Religion*, *29*(1), pp.47-60.	Not an empirical review
Jain, A. (2020) *Peace Love Yoga: The Politics of Global Spirituality*. Oxford University Press.	Book
Ji, C., Hu, P. and He, Z. (2007) 'Secular growth trends in the Chinese urban youth and its implications on Public Health. *Beijing da xue xue bao. Yi xue ban=' Journal of Peking University. Health Sciences*, *39*(2), pp.126-131.	On children
Kelly, J. (2017) 'Are societies paying unnecessarily for an otherwise free lunch? Final musings on the research on Alcoholics Anonymous and its mechanisms of behaviour change.' *Addiction*, *112*(6), pp.943-945.	Not empirical/opinion piece
Kelly, J. (2017) 'Is Alcoholics Anonymous religious, spiritual, neither? Findings from 25 years of mechanisms of behavior change research.' Addiction, 112(6), pp.929-936.	Not an empirical review
Krause, N. (2006) 'Exploring the stress-buffering effects of church-based and secular social support on self-rated health in late life.' *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *61*(1), pp.S35-S43.	On church attendance
Rogers, M., Wattis, J., Stephenson, J., Khan, W. and Curran, S. (2019) 'A questionnaire-based study of attitudes to spirituality in mental health practitioners and the relevance of the concept of spiritually competent care.' *International journal of mental health nursing*, *28*(5), p.1165-1175.	Not related to SBNR
Salimi, H., Yazdanpanah, F., Ahmadi, M., Zarei, E. and Hoseinzadeh, P. (2017) 'Secularism and spirituality constructs in explanation of Public Health in nursing and midwifery students.' *Iranian Journal of Psychiatric Nursing,* 4(4), p.58-65.	Not been translated into English
Scalora, S., Anderson, M., Crete, A., Drapkin, J., Portnoff, L., Athan, A. and Miller, L. (2020) 'A Spirituality Mind-Body Wellness Center in a University Setting; A Pilot Service Assessment Study.' *Religions*, *11*(9), p.466.	Not directly relevant
Jang, S. and Franzen, A. (2013) 'Is being "spiritual" enough without being religious? A study of violent and property crimes among emerging adults.' *Criminology,* 51(3), pp.595-627.	Useful but not health-related

Appendix 6

Full list of the references for the SBNR literature review

First author	Full reference
Baker	Baker, J., Stroope, S. and Walker, M. (2018) 'Secularity, religiosity, and health: Physical and mental health differences between atheists, agnostics, and non-affiliated theists compared to religiously affiliated individuals.' *Social Science Research*, *75*, pp.44-57.
Hayward	Hayward, R., Krause, N., Ironson, G., Hill, P. and Emmons, R. (2016) 'Health and wellbeing among the nonreligious: Atheists, agnostics, and no preference compared with religious group members.' *Journal of religion and health*, *55*(3), pp.1024-1037.
Kelly	Kelly, J. and Eddie, D. (2020) The role of spirituality and religiousness in aiding recovery from alcohol and other drug problems: An investigation in a national US sample. *Psychology of religion and spirituality*, *12*(1), p.116.
McClure	McClure, P. and Wilkinson, L. (2020) 'Attending substance abuse groups and identifying as spiritual but not religious.' *Review of Religious Research*, pp.1-22.
Mercadante	Mercadante, L., (2020) Spiritual Struggles of Nones and 'Spiritual but Not Religious'(SBNRs). *Religion*s, 11(10), p.513.
Saunders	Saunders, D., Norko, M., Fallon, B., Phillips, J., Nields, J., Majeed, S., Merlino, J. and El-Gabalawi, F. (2020) 'Varieties of Religious (Non) Affiliation: A Primer for Mental Health Practitioners on the "Spiritual but Not Religious" and the "Nones"'. *Journal of Nervous and Mental Disease,* 208(5), p.424-430.
Speed	Speed, D. and Fowler, K. (2016) 'What's God got to do with it? How religiosity predicts atheists' health.' *Journal of religion and health,* 55(1), pp.296-308.
Van der Tempel	Van der Tempel, J. and Moodley, R. (2020) 'Spontaneous mystical experience among atheists: meaning-making, psychological distress, and wellbeing.' *Mental Health, Religion and Culture*, pp.1-17.
Watts	Watts, G., (2019) 'Recovering enchantment: addiction, spirituality, and Charles Taylor's malaise of modernity.' *Journal of Contemporary Religion,* 34(1), pp.39-56.
Willard	Willard, A. and Norenzayan, A. (2017) "Spiritual but not religious": Cognition, schizotypal, and conversion in alternative beliefs. *Cognition, 165*, pp.137-146.

Appendix 7

Concept Analysis of spirituality

Copy of: Holt, N. (2016) What Does the Word Spirituality Really Mean? In (2016) *Spirituality: An Interdisciplinary View* (pp. 79-97). Brill.

Abstract

Currently, most of the world's population is involved in some form of spiritual practice. Spirituality is frequently regarded as the missing dimension of healthcare, yet it is under-researched, frequently misinterpreted and often neglected, which can have significant moral, legal and personal consequences. One overriding issue is that there does not, as yet, appear to be a single, comprehensive definition of the term, and people's understanding of what it means differs enormously. A greater understanding of the concept is important as it can contribute towards the clarification of what spirituality means and increase its relevance for those seeking to improve their own or others' health and wellbeing. This presentation highlights how the use of Walker and Avant's concept analysis model informed a fuller understanding of the concept to include faith and religion, but also many other representations such as self-transience, connectedness, holism and a sense of self. These suggest that spirituality can be defined as peoples' personal, religious creeds or practices, but also include principles, values, modes of behaviour and ways of achieving peace of mind which have broader relevance for those seeking to deliver holistic care or improve the health and wellbeing of others. Key Words: Spirituality, connectedness, holism, self and religion.

Conceptual analysis of spirituality

The Concept Analysis model by Walker and Avant (2014) was used as it appears to be the most influential model used in the health and wellbeing disciplines (Hussey and Smith, 2008; Metaxiotis and Psarras, 2005). However, it should be recognised that there are other concepts analysis models, such as Roger and Knafl (2000) and Wilson (1969). The Walker and Avant (2014) model has reduced Wilson's thirteen-step model to eight steps (Nuopponen, 2010) and the framework is purported to be a relatively easy and straightforward process to follow:

1. Select a concept.
2. Determine the aims and purposes of the analysis.
3. Identify all the uses of the concept that you can discover.
4. Determine the defining attributes.
5. Identify a model case(s).
6. Construct additional cases.

7. Identify antecedents and consequences.
8. Define empirical referents.

The Walker and Avant (2014) method has been criticised for being too systematic and reductionist in its process and having a positivist paradigm (Rodgers, 1989). Despite these criticisms, the model was useful to the researcher because of its step by step and interactive approach to analysing a concept, thereby facilitating an in-depth analysis. Furthermore, it has been successfully used by other researchers, and it appears to be the most up to date model for concept analysis.

Select a concept

Walker and Avant (2014) recommend that the concept which is being analysed should be interesting to the investigator. The term spirituality is a fascinating concept to the researcher because it seems to be an under-researched area and may have many potential effects on people`s health and wellbeing. The word spirituality also interests the student on a personal level as her last study looked at 'how dog ownership impacts people`s health and wellbeing.' This study showed that dogs potentially had a positive effect on people`s spiritual health by making their owners feel calm and at peace which the researcher was not expecting at all. Moreover, the term spirituality is important and valuable to the current study and to further theoretical developments in this discipline. Finally, this is vital as the relationship of this concept to health and wellbeing will be further explored in my thesis; in order to achieve a holistic understanding of what spirituality means will be necessary.

Determine the aims and purposes of analysis

The second step in Walker and Avant's (2014) model is to answer the vital question 'why am I doing this analysis?'. The purpose of the analysis was to distinguish between ordinary and scientific usage of the same concept, to clarify the meaning of the existing concept, to add to existing theory, to develop an operational definition (Gante, 2010; Simmons, 2010) and to fully understand what spirituality means. This is because it is frequently misinterpreted and is regularly viewed as the lost dimension of health and wellbeing (Narayanasamy et al., 2002). In addition, it needs to be identified that the more abstract a concept, the less able it is to be directly measurable (Chinn and Kramer, 1999). Spirituality can be considered an abstract concept because of its intangible and subjective nature (Tanyi, 2002). Hence, it is easy to see why there has been prolonged ambiguity on how the concept is defined and incorporated into research, practice, and education (Tanyi, 2002). This analysis

aims to contribute towards clarification of the meaning of spirituality and then apply its relevance to health and wellbeing today.

Furthermore, the fullest possible understanding of what spirituality means would help to delineate what the study is evaluating. It has been suggested that neglect of spirituality can have significant moral, legal and personal consequences of which people are often unaware. Thus, the analysis aimed to explore what the true meaning of spirituality is so that the attributes can be applied to help measure its effects on health and wellbeing.

Identify all the uses of the concept that you can discover

Following Walker and Avant's (2014) recommendation, the first step is to identify all the uses of spirituality. The original term of spirituality comes from the Latin word 'spiritus' which was translated into 'spirit'. In English grammar 'spirituality' is the noun; the adjective and the adverb is 'spiritual'. The words spirituality, spiritual and spirit are sometimes used interchangeably (Jesse, Schoneboom and Blanchard, 2007; Kinjerski and Skrypnek, 2004; Newlin, Knafl, and Melkus, 2002). However, the term can theoretically change depending on the context in which person uses the term (Greenstreet, 2001). In other languages, for example, the word spirituality is translated as the 'espirit' in French and German spirituality is translated into 'geistigkeit'. Further information about the use of spirituality was obtained by a search of the literature on spirituality spanning over the past 30 years. Database searches were selected by using the Canterbury Christ Church Library E-Search. The criteria for selection included scholarly articles and books with a definition of spirituality and research studies that had an emphasis on the meaning of spirituality to individuals'.

An initial definition of spirituality was obtained from the Oxford English Dictionary (2014), which yielded numerous definitions of the keywords, for example, spirit, spiritual or religious. The various dictionary definitions appear consistent with the premise that spirituality is a multidimensional concept. The Oxford English Dictionary (2014) defined spirituality as 'the quality or condition of being spiritual; attachment to or regard for things of the spirit as opposed to material or worldly interests'. A USA dictionary defines 'spirituality as the quality or state of being concerned with religion or religious matters: the quality or state of being spiritual' (Merriam Webster, 2014). Other well-known dictionaries such as Collins, Cambridge and Macmillan highlight similar definitions. The difference between these two definitions is worth commenting on in that the USA appears more focused on the religious aspect while the UK focuses more on a multidimensional and connectedness aspect. This might be due to the fact historically the USA, they do have a reputation of appearing to be more religious.

Spirituality appears in several thesauruses. According to the Oxford Thesaurus (2014), related concepts to spirituality include nonmaterial, metaphysical, ethereal, intangible, immaterial, incorporeal sacred, religious, holy, divine, ethereal, faith, devotional and otherworldly. However, according to an American Thesaurus related concepts to spirituality included: anagogic, religious, holy, clear, far-seeing, immaterial, incorporeal, inherent, material, pneumatoscopic, subjective, unextended, animastic, disembodied, holistic, imponderable, incorporeal, innate, moral, realized, timeless, connected, universal, asomatous, ectoplasmic, faith, incarnate, indescribable, innominate, organic, revealed, unearthly, unspeakable extramundane, holy, immaterial and incomprehensible (Thesaurus.com, 2014). This indicates that spirituality has many related words and dimensions. The significant words that appear most frequently included religious, holy, faith and connected. There appears to be a contrast between the two countries definitions in that the USA seems to focus on a more formalised religion/belief in a higher power than the UK description.

Several researchers, for instance, Greenstreet (1999) propose that there are numerous uses of the concept of spirituality. It has been proposed that the definitions of spirituality can vary in their degree of commonality, but do not reflect a consensus of thought; for instance, Dossey (1989), O'Brien (1982), Hover-Kramer (1989), Narayanasamy (1991), Burkhardt (1989), Koenig et al. (2001). Gorsuch and Miller (1999) proposed that most people have some kind and level of depth or intensity of spirituality. Heriot (1992) and O'Hara (2002) imply that what people mean when they use the word spirituality varies enormously; for example, when somebody says that they are spiritual this could mean they enjoy meditation or that they like to go for solitary walks. It may also mean that they appreciate great art or that they love music. Waaijman (2002:460) advises that above all, spirituality usually means that 'people believe in the infinite value of human love'. Spirituality can be viewed as part of pleasure, happiness or aspect of life satisfaction (Büssing and Ostermann, 2004). In addition, the use of spirituality may differ according to a person's ethnic origin, culture, and environment. Therefore, spirituality can be seen as part of pleasure, happiness or an aspect of life satisfaction and can change in the context in which people use the term.

Theological definition

It should be noted that the concept of spirituality within different disciplines can have opposing meanings. In Theology and Religious Studies literature, the term spirituality has been variously used by theorists as 'the human response to God`s gracious call to a relationship with himself' (Benner, 1989:20), 'a subjective experience of the sacred' (Vaughan, 1991:105) and that 'vast realm of human potential dealing with ultimate purpose, with higher entitles, with God with love, with compassion,

with purpose' (Tart, 1983:4). Furthermore, Zinnbauer et al. (1997) argued that the term spirituality and religiousness have been used interchangeably and inconsistently by some authors; for example, Miller and Martin (1988:14) who frequently interchange the terms even after they explicitly stated that spirituality may or may not include involvement in organised religion. It has been claimed that religion and spirituality are used similarly in the sense that they both preach loyalty to justice and compassion. Zinnbauer et al. (1999) implied that both concepts could shape the mind of the individual and it is individually oriented in content. Doane (2013) claimed that a perfect combination of both is needed in the present day for people to have a sense of 'balance' in their life. Equally, it should be recognised that some people might claim they do not need spirituality or religion to make them feel balanced.

It has been argued that there are variations between the uses of the term spirituality and religion. It has been proposed that religion tends to be used to mean outwardly guided, while spirituality is generally seen as being inwardly guided (Janis, 2008). Kaplan (2013) contends that another difference between the term spirituality and religion is that religion is often viewed as more institutionally based, more structured, and more traditional and may be associated with organised, well-established beliefs. Spirituality, on the other hand, refers to the intangible and immaterial and thus may be considered a more general term, not associated with a particular group or organisation (Newlin, Knafl and Melkus, 2002). Mitroff (2003:375) states that 'people should not promote religion under the guise of spirituality, because they are completely different concepts which have different target audiences.' Another difference is that with religion people tend to believe in a higher being whereas, with spirituality, this tends not to be the case (Zinnbauer et al., 1997). Also, those who are religious tend to feel devoted to faith, while those who consider themselves spiritual may not (Hill et al., 2000). However, it has also been proposed that the term spirituality is linked to faith because faith and spirituality are associated with a more optimistic life orientation, greater perceived social support, higher resilience to stress and lower levels of anxiety (Pardini et al., 2000). Thus, this has identified that there is a likely connection between spirituality, religion and faith.

Business management and leadership literature

There is also literature that suggests the term spirituality is used as 'the ability to be creative, to alter the boundaries of current thought, to address problems of good and evil, to exercise extended choice, to seek higher meaning in life, and to transform both the self and life situations in positive ways' (Fontana, 2003; 81). Within business literature, spirituality is viewed as the basic feeling of being connected with one's complete self, others, and the entire universe (Mitroff and Denton, 2000).

However, Syukri (2013) who is also from a business discipline, uses the term spirituality as a way to see beyond mere outer appearances and the five senses to an intuitive perception of the causes behind outer conditions'. Meraviglia (1999) proposes that individuals experience their spirituality in special ways and through an ongoing holistic process. While Farran et al. (1989) show how the spiritual dimensions were influenced by an individual's cultural and developmental life experiences. The philosophers Dossey (1989) and O'Brien (1982) consider spirituality to be synonymous with a transcendent awareness that is qualitatively more satisfying than the everyday world of the material. Yet even within the same discipline, there are disputes, as another philosopher Hover-Kramer (1989: 29) indicates in describing 'self-transcendence as essential for wholeness'. This is clarified further by Narayanasamy (1991: 4) who said 'I see spirituality as my being; my inner person. It is who I am, unique and alive. It is expressed through my body, my thinking, my feelings, my judgements and my creativity.' Therefore, spirituality may potentially be used as a way to define a divine experience and a connection with many aspects of people's lives.

Psychology literature

In contrast, spirituality as viewed in some of psychology literature was an expression of one's internal motives and desires concentrating on the self instead of God (Pargament, 1997). The psychological perspective of spirituality tends to examine the mental processes for discovering what gives people meaning and where they look for guidance and authority (Farran et al., 1989). Seligman and Csikszentmihalyi (2000) suggest that in humanistic psychology, the focus is on personal growth potential within the individual and Dombeck and Karl (1987) argue that spirituality refers to one's ability to attain inward harmony and self-actualisation. Other psychologist authors have more broadly described spirituality in psychology as the way people choose to lead their lives (Muldoon and King, 1991). However, Frankl (1988) described spirituality more extensively (than just psychologically) when he incorporated theological thinking in his theory of human motivation. Frankl (1988) emphasizes that people are primarily motivated to find their meaning and purpose in life and goes on to state that individual meaning cannot be created; it can only be discovered through the spiritual dimension. He goes on to say that all people can transcend themselves, especially in periods of unavoidable personal suffering. Helminiak (1996) also describes spirituality as being part of the universal dimension of the mind and his conceptualization of spirituality combines a theological understanding of connectedness to God with a psychological focus on connectedness with the self. Thus, spirituality can potentially be viewed as part of the individual's self or self-transcendence which can be potentially transferred into people's faith and religious attributes.

Sociological literature

Within the sociological literature, people are viewed as being strongly influenced by other people and by the groups in which they live, so if spirituality is seen to have an important role in the community, people are more likely to engage with it. Russell (1986) stated that in the past, religious groups have predominately influenced personal spirituality, but now an internalised spirituality is more prevalent. In the sociological literature, spirituality is described as the spiritual practices and rituals of groups of people as well as the social morality within personal relationships (MacQuarrie, 1992). Hiatt (1986) conducted a review and found that spirituality is a personal search for meaning that underlies the dimensions of mind and body. These characteristics are similar to the psychological understanding of spirituality particularly highlighting the connective and holistic elements.

Health and wellbeing literature

In the health and wellbeing literature spirituality seems to be discussed as being used as a partnership/aspect of people's self, faith and supernatural relationship. Highfield (1992) a researcher for the Department of Health describes spirituality as the essence of human beings that transcends the immediate awareness of the self. However, Stoll (1989) describes spirituality as one's sense of personhood that gives life. Several authors incorporate a personal relationship to God in their discussion of the spiritual dimension (Carson, 1989; Emblen, 1992; Stuart, Deckro, and Mandle, 1989). Others focus more on the psychological perspective of spirituality with its primary emphasis on the self and one's capacity for healing and self-evolution (Clark et al., 1991; Dawson, 1997; Goddard, 1995; Hall, 1997; Taylor and Ferszt, 1990). In a nursing context, spirituality is generally understood as encouraging human contact in a compassionate relationship and moves in whatever direction need requires' (Royal College of Nursing, 2009). Thomas (1989) describes spirituality from the medical perspective by emphasizing the interactions between the dimensions of mind, body, and spirit. Stoll (1989) integrates the multiple perspectives of connectedness by explicating the vertical and horizontal dimensions of spirituality. The vertical dimension is one's connectedness with God or a supreme being, and the horizontal dimension is one's relationship with oneself, other people or nature. This research implies that spirituality is related to people's holistic self and potentially links with other areas of their lives.

Schlehofer et al. (2008) recommend that laypeople may use the term spirituality as an associate religion rather than spirituality with personal beliefs, community affiliation, and organised practices. Houtman and Aupers (2007) propose that the modern term of spirituality is a blend of humanistic psychology, mystical and esoteric traditions, and eastern religions. Roof (2001) suggested that

spirituality has also been described in terms of ultimate belonging or connection to the transcendental ground of being. Schmidt (2005) proposed that some people may define spirituality in terms of a relationship with God, to fellow humans, or the earth. Others define it in terms of devotion and commitment to a particular faith or form of practice. Wilber (2000) proposed that an integral perspective of spirituality would presumably include all these different views. All this research implies that spirituality involves a holistic process, which can be part of some people`s development and also be viewed as an experience.

Spiritual practices

The term spirituality has been applied in many contexts and ideas such as spiritual care, spiritual experience, awakening, spiritual wisdom, spiritual empowerment, spiritual freedom or spiritual living, spiritual life, and the list is endless. To reiterate the fact that spirituality has been applied to many terms and illustrated that they have many meanings; it covers a broad spectrum for application to various aspects of life. Furthermore, according to Carrette and King (2005), there is a potential variation between the origin of spirituality and how spirituality is used now. Thus, this further illustrates the complexities around spirituality.

Alternative views

There are many practices of spirituality. Burkhardt (1989) identified that elements of spirituality can include people's personal creeds, principles of behaviour and ways of achieving peace of mind. Other expressions include 'prayer, meditation, music, interactions with others, nature, and a relationship with a higher power' (Burkhardt, 1989: 60). Roof (2001) proposed that spiritual practices can also include meditation, mindfulness, prayer, the contemplation of sacred texts, ethical development, and the use of psychoactive substances. Breitbart (2002) adds that love and compassion are often described as the mainstay of spiritual practices. It has been suggested that spiritual practices can involve meaningful activities, such as art, cooking, singing, and dancing (Nelson et al., 2002). There are other philosophical thinkers, such as Carrette and King (2005), Eck (2001) and Hanegraaff (1996) who give similar accounts of the elements of spirituality, demonstrating that there are many practices of spirituality.

There may be some people who argue that spirituality does not exist at all. An example of this could perhaps be Professor Dawkin (2006) who suggests that there is no such notion as spirituality or religion, he goes on to further claim that belief in such ideas can be harmful to the people. This can affect the usage of the word. Furthermore, Moberg (2002) proposed that some people may argue that

spirituality is non-existent as it cannot be physically measured. It has also been argued that spirituality can be viewed as 'woolly' and lacking a definition (Kees, 1997). Some suggest that spirituality is used as a crutch for the weak (Eisler and Montouori, 2003). Sloan et al. (2001) and Ver Beek (2000) suggest that some people may argue that spirituality is a mask and a way for people to hide from dealing with real problems in their life. However, Burkhardt (1989;72) argued that he prefers the term 'spiriting' to spirituality which he defines as 'the unfolding of mystery through harmonious interconnectedness that springs from inner strength as it portrays the process inherent within this concept'. Richards and Bergin (1997) add that the notion of spirituality is a widely debated topic, there appears to be an assumption that most people have an element of and a relationship to spirituality. To sum up, some people may argue spirituality does not exist and others go as far to state it is harmful and some may struggle with the term, therefore all these factors need to be taken into account when defining spirituality.

In summary, it has been identified that the term spirituality has many definitions and uses, the study will consider all aspects of the concept as this is likely to yield richer meaning. Now all the uses of spirituality have been highlighted it has been decided that all aspects of spirituality need to be considered particularly in relation to health and wellbeing.

Determining the defining attributes of spirituality

Walker and Avant (2014) regard the fourth step as 'the heart of concept analysis.' This is determining the defining attributes or defining characteristics of the concept. This will try to illustrate the cluster of attributes that are most frequently associated with the concept and that allows the analyst broad insight into the concept (Walker and Avant, 2014). The fact is that spirituality has been applied to many terms and can have many meanings; it has a broad spectrum for application to various aspects of life. As a consequence of having so many definitions, I created a table looking at over one hundred author definitions of spirituality and marking off the main aspects the definitions covered. These key attributes were chosen specifically to be focused on spirituality related to health and wellbeing because these fundamental attributes are likely to influence this thesis. The defining attributes of spirituality that appear over and over again were connectedness, faith, holism, religion and self-actualisation. Each attribute will be described to further clarify the understanding of the concept. The key attributes of spirituality are:

- Connectedness: The link with self, others, nature or a higher being.
- Holism: A multi-dimensional feature affecting every part of a person's life.

- Self-actualisation/self-acceptance: A person feels complete in relation to their life.
- Multidimensional: Several dimensions or aspects.
- Religion: A social institution in which a group of people participate rather than an individual search for meaning.
- Faith: A belief in and an assent to something greater than the self.

Other attributes of spirituality can include:

- Love: a deep affection, great interest, and pleasure in something.
- Happiness: a feeling of pleasure.
- Hopefulness: a feeling of expectation and desire for a particular thing to happen.

Identifying a model case

Due to word limitations, these aspects of the model were omitted for this concept analysis.

Identify antecedents and consequences

The seventh step in Walker and Avant's (2014) model is to identify antecedents (those events or incidents that must occur or places before the occurrence of the concept) and consequences (those events or incidents that occur as a result of the occurrence of the concept).

Antecedents

The antecedents of the concept of spirituality are likely to include one or more of these: transcendent awareness, self-awareness, professional commitment, sensitivity, intentionality and possibility of religious affiliation. People's transcendent awareness can be an important antecedent of spirituality (Smith, 2006). By acknowledging the fact that humans are potentially spiritual beings, people can identify and plan to fulfil their unique spiritual needs (Meraviglia, 1999). Factors such as peoples' spiritual awareness and evolution (Tanyi, 2002), spiritual wellbeing and prior experience of crises and spiritual issues in their personal lives (Burkhart and Hogan, 2008), and receiving education and information about spirituality, spirit and spiritual may promote people's awareness of the transcendent dimension of life (Ross, 2006). People's self-awareness is potentially another antecedent of the concept of spirituality. This can include people's awareness of personal beliefs, attitudes, values, fears, prejudices, and critical analysis of self and personal experiences (McSherry, 2006). A person`s religious affiliation, religious insight, and self-improvement (Lundmark, 2006) facilitate the identification of peoples' spiritual needs and can also be part of the provision of spiritual care. Moreover, people's ability to understand, connect and accept others' feelings and behaviours are among the essential prerequisites for the fulfilment of people's spiritual needs.

Consequences

The use of spirituality may lead to positive consequences, such as healing, promotion of spiritual wellbeing, psychological adaptation and feelings of satisfaction for people, and promotion of spiritual awareness and overall satisfaction. The delivery of spirituality within spiritual care helps people develop resilience, hope and coping skills (Narayanasamy, 2001) and might also be able to assist people effectively cope with the critical situations of life (Cavendish et al., 2006). It has been suggested other consequences of spirituality can include greater reality acceptance (Mok et al., 2010), inner peace (McEwen, 2005), reality-based peace (Mayer, 1992), alleviation of anxiety (Carson and Koenig, 2008), alleviation of depression (Mauk and Schmidt, 2004), alleviation of psychological distress (Meraviglia, 1999), enhanced resiliency (Smith, 2006), optimism in stressful situations (Brown and Lo, 1999), effective stress management (Battey, 2009), increased self-control (Martsolf and Mickley, 1998) and self-confidence (Meraviglia, 1999), and reclaim of self-concept (Mattison, 2006). Moreover, it has been proposed that spirituality can improve peoples' spiritual awareness (Narayanasamy, 2001) and provide overall satisfaction (Rieg et al., 2006). Consequently, this may give meaning and purpose to people lives. There may also be negative consequences such as stopping life-saving medications, failing to seek timely medical care, unhealthy belief systems and folk healers who can control by communing with the "spirit world".

Defining empirical referents

The last step of concept analysis is defining empirical referents for the key attributes of the concept. The empirical referents are defined to answer the following questions: 'How we can measure the concept?' and 'What are the real-world applications of the concept?'. Walker and Avant (2011) propose that they are related to the theoretical underpinnings of the concept. Based upon the reviewed literature, empirical referents of spirituality included, but were not limited to:

- Helping people re-establish relationships with self, family, friends and a higher being (McEwen, 2005).
- Supporting people and their family members' spiritual and religious practices (Carpenter et al., 2008).
- Listening and engaging with people, animals, the environment and so forth (Ramezani et al., 2014).
- Creating and promoting confidence in relationships (Dell'Orfano, 2002).
- Emphasising the positive aspects of situations (Mauk and Schmidt, 2004).

• Considering the uniqueness and individuality of each person (Clark et al., 2003).
• Helping people to respect the personal dignity of each other (Callister et al., 2004).
• Expressing unconditional love (Tanyi, 2002).
• Helping people develop their spiritual coping strategies (Mok et al., 2010).

To summarise, spirituality has different empirical referents in alternative contexts, situations and cultures the term is implied. Spirituality is interconnected with the experiences and expressions of one's spirit in a unique and dynamic process reflecting faith in a Supreme Being; connectedness with oneself, others, nature or God and integration of the dimensions of mind, body, and spirit. As a consequence of the concept analysis, this study definition of spirituality will be defined as:

'*That most human of experiences that seeks to transcend the self and find meaning and purpose through connection with others, nature, and/or a supreme being, which may or may not involve religious structures or traditions.*'

Elements and practices of spirituality can include music, prayer, and any activities a person feels contribute to their spiritual engagement. By understanding all that spirituality may represent for people, this thesis can assess and care for specific spiritual needs. Finally, it should be recognised that as this study develops, a firmer and different definition of spirituality may arise.

Appendix 8

Copy of the questionnaire

Question 1

Do you consider yourself healthy?

- Yes
- No, please would you tell us why you feel this way?
- Not sure

Question 2

Do you consider yourself to be spiritual?

- Yes
- No
- Not sure

Question 3

What does spirituality mean to you?

Question 4

Researchers have identified several possible aspects of spirituality that we are interested in. Please tick which of these words or phrases have any bearing on your own sense of spirituality if you have one (Please tick all those that apply).

- Feeling connected to someone or something outside yourself.
- Feeling complete as a person.

- [ ] Feeling that you can achieve your full potential.
- [ ] Having a sense of purpose
- [ ] Experiencing a sense of love from someone or something outside yourself.
- [ ] Experiencing something, which makes you feel happy with your life.
- [ ] The above words and phrases are not applicable to me.
- [ ] Please add any words or phrases, not on the above list which are important to you when you think about spirituality.

Question 5

Do you engage in regular spiritual activities or practices?

- ○ Yes
- ○ No
- ○ Not sure

If **Not sure** Is **Selected**, Then Skip To **Please select one answer from each of...** Skip Logic

Question 6

Please state what these spiritual activities are below:

Question 7

In your own words, please say what effects these spiritual activities or practices have on you, if any, as an individual?

Question 8

How often do you engage in the spiritual activities or practices you mentioned above?

- More than once a day
- Once a day
- A few times a week
- I would prefer not to say

Question 9

Where do you engage with spiritual practices?

- At home
- Outside
- In a spiritual/ religious building
- Other. Please state where:

Page Break

Question 10

Please select one answer from each of the questions below by clicking the numbers in each of the columns to show which best represents the impact of spirituality has on your health:

Spirituality is defined as:

'that which seeks to transcend self and find meaning and purpose. This could be achieved through connection and engagement with others, the surrounding environment or oneself.'

Please give just one response to each of the following items as follows:

	It has a strong negative effect	It has a somewhat negative effect	It has no effect at all	It has a somewhat positive effect	It has a strong positive effect
My overall physical health					
My overall physical fitness					
The amount of exercise I do					
Prevention of illness					
My diet					
My sleep					
My emotional health					
My joy of life					
My mood					
My self-esteem					
My communication with others					
My concentration					
My ability to think clearly					
My stress levels					
My social health					
My relationship with my family					
My relationship with my partner (if applicable)					
My ability to make friendships					
My ability to maintain friendships					

My engagement in the wider community	○	○	○	○	○
My sense of personal safety	○	○	○	○	○
My sense of belonging	○	○	○	○	○
My spiritual health	○	○	○	○	○
Engagement in spiritual activities	○	○	○	○	○
My ability to engage in spiritual activities	○	○	○	○	○
How often I engage in spiritual activities	○	○	○	○	○
Feeling connected with the world	○	○	○	○	○
Feeling connected to something bigger than myself	○	○	○	○	○
My feeling of being at peace	○	○	○	○	○

Question 11

How does your spirituality affect the following? (skip those who do not apply)

Your physical health (for example, exercise, diet, movement, lifestyle choices).

Your emotional health (for example, feeling happy, joyful, sad or stressed).

Your social health (for example, going out with friends, engaging with people in the community).

Your engagement in the wider community (for example, feeling connected and a sense of belonging).

Your spiritual health (for example, example, a way of achieving peace of mind and being at peace with oneself).

Page Break

Question 12

What is your country of birth?

- England
- Wales
- Scotland
- Northern Ireland
- Elsewhere, please write in the name of the country:

Page Break

Question 13

Please choose the option that best describes your ethnic group or background:

- White: English/Welsh/Scottish/Northern Irish/British
- White: Irish
- White: Any other White background, write in:
- Mixed White and Black Caribbean
- Mixed White and Black African
- White and Asian

Mixed/multiple ethnic groups:

Any other mixed/multiple ethnic backgrounds, write in:

Asian/Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background, write in:

Black/African/Caribbean/Black British

African

Caribbean

Any other Black/African/Caribbean background, write in:

Other ethnic groups, please state:

Question 14

How old are you?

18-30

31-40

41-50

51-65

66+

Prefer not to say

Question 15

What is your highest educational achievement?

No qualifications

GCSEs or equivalent

A-Levels or Equivalent

Degree

Postgraduate qualification

Prefer not to say

Question 16

Are you currently employed?

Yes, if applicable, what is your present job title?

No

Prefer not to say

Question 17

If applicable, what is your annual income, in other words, how much do you earn per year?

Prefer not to say

£0-£15,000

£15,000-£30,000

£30,000-£50,000

£50,000-£100,000

£100,000 +

Question 18

Please select your gender.

- Male
- Female
- Other
- Prefer not to say

Finally, *thank you for your time. We really appreciate your kind participation! It would be appreciated if we could contact you for an interview about your responses. If you do not mind being contacted, please leave your email address or mobile phone number here:*

Appendix 9

Social media platforms

The questionnaire advert was posted on different groups on the social media platforms that were used to recruit the participants.

Social Media Website	**Weblink**	**Date Initially Posted Online**
Facebook	Spiritual England https://www.facebook.com/groups/spiritualengland/ Spiritual but Not Religious https://en-gb.facebook.com/public/SBNR Spiritual Unite https://www.facebook.com/spiritualunite/ Spiritual Social Networks https://www.facebook.com/SpiritualSocialNetworks/ Spiritual Science https://www.facebook.com/SpiritScienceOfficial/ Spiritual Thoughts and Sayings https://www.facebook.com/SpiritualTS/?__tn__=%2CdC-R-Randeid=ARDc4wpk41K9ZYS6f6fUFaQ8z7slZEK4iPEN-YQ2cBnZhXYBw2kbHNyh_XJOKkqXktpP4Xch_alennWzandfref=nf My own Facebook Account https://en-gb.facebook.com/public/Nicole-Holt	6th August 2015
Twitter	My own Twitter Account https://twitter.com/Nicoleholt21	6th August 2015
Reddit	https://www.reddit.com/r/DebateReligion/comments/tj0an/to_all_sbnrs_spiritual_but_not_religious_what_you/ https://www.reddit.com/r/vignettes/comments/6rnjdt/sbnr_spiritual_but_not_religious/	6th August 2015
LinkedIn	My own LinkedIn Account https://uk.linkedin.com/in/nicole-holt-432bb449?trk=people-guest_profile-result-card_result-card_full-click	6th August 2015

Appendix 10

Letter of ethical approval

Dear Nicole,

Confirmation of ethics compliance for your study *"What effect does personal spirituality have on people's health?"*

I have received your Ethics Review Checklist and appropriate supporting documentation for proportionate review of the above project. I confirm that your application, supported by the documentation provided, fully meets the requirements for proportionate ethical review under the terms of this University's Research Ethics and Governance Procedures.

In confirming compliance for your study, I must remind you that it is your responsibility to follow, as appropriate, the policies and procedures set out in the *Research Governance Handbook* (http://www.canterbury.ac.uk/centres/red/ethics-governance/governance-and-ethics.asp) and any relevant academic or professional guidelines. This includes providing, if appropriate, information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct of the study over its course should be notified to the **Research Office** and may require a new application for ethics approval. It is a condition of compliance that you **must** inform me once your research has been completed.

Wishing you every success with your research

Yours sincerely

Roger Bone

Research Governance Manager

Tel: +44 (0)1227 782940 ext 3272 (enter at prompt)
Email: roger.bone@canterbury.ac.uk

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Appendix 11

Copy of the participant information sheet

Information Sheet

What effect does personal spirituality have on your health?

Hi there,

Very little research has investigated how people believe spirituality might be able to affect people's health in the UK. Please, could you take 10 minutes of your time to contribute to this study? You will be kept anonymous, as I do not require your name or personal details.

****I am especially targeting those who consider themselves to be *spiritual but not religious* and *healthy****

This study hopes long term to shed light on an area that has been fully researched yet.

This questionnaire will be closed approximately on the 6th of November 2015.

Thank you very much for your help.

Best Wishes,

Nicole,

Canterbury Christ Church University, Kent, England

CLICK HERE TO ENTER SURVEY

Appendix 12

Consent Form

This study is being conducted at Canterbury Christ Church University (CCCU), England as part of a PhD degree.

Background
The study will explore the effect of spirituality on people's health and wellbeing and what it means to them as there is very little research in this area. This study is particularly interested in those who would define themselves as spiritual but not religious.

What will you be required to do?
You will be asked to fill in the questionnaire and answer the questions as honestly as possible. The questionnaire will take about 20 minutes to complete. There is a choice at the end of the survey to be contacted and interviewed about your answers, **if you do not wish to be contacted, please do not leave your contact details.**

To participate in this research, you must:

To participate in this study, you are required to be **over 18 in the UK, perceive yourself to SBNR and in a generally healthy state.**

We define healthy as feeling relativity well in yourself. It doesn't matter if you have a long-term illness or disability as long as you think you are healthy, this questionnaire is suitable for you.

Procedures
You will be asked to complete a questionnaire. If you have difficulty reading it, please download Claro reader Plus software by following this link: https://www.clarosoftware.com/. It will read the questions to you.

Feedback
A summary of the findings will be placed on my Facebook, Twitter and LinkedIn page once the study has been completed. You can also email: nch12@canterbury to request a copy of the findings. Please be assured all personal data will not be placed on these social network sites.

Confidentiality
This study does not require you to provide your name. You will remain anonymous. All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. I will also have remote desktop access at home of the data which will also be covered by the university data protection requirement. Data can only be accessed by my supervisors and myself.

Dissemination of results
An electronic version of the final PhD Thesis will be lodged in the library of Canterbury Christ Church University. A short summary of the main findings will be posted on my main Facebook page, and people will be notified through Twitter. Some findings may be published in academic journals or my blog to inform future work by other researchers.

Deciding whether to participate
By filling in this questionnaire, you voluntarily agree to give consent to be part of the study. Should you change your mind about participating, you are free to withdraw at any time without having to give a reason, and your data will be removed from the study.

Any questions?
Please send any questions that you might have relating to this research project to nicole.holt@canterbury.ac.uk.

☐ I agree

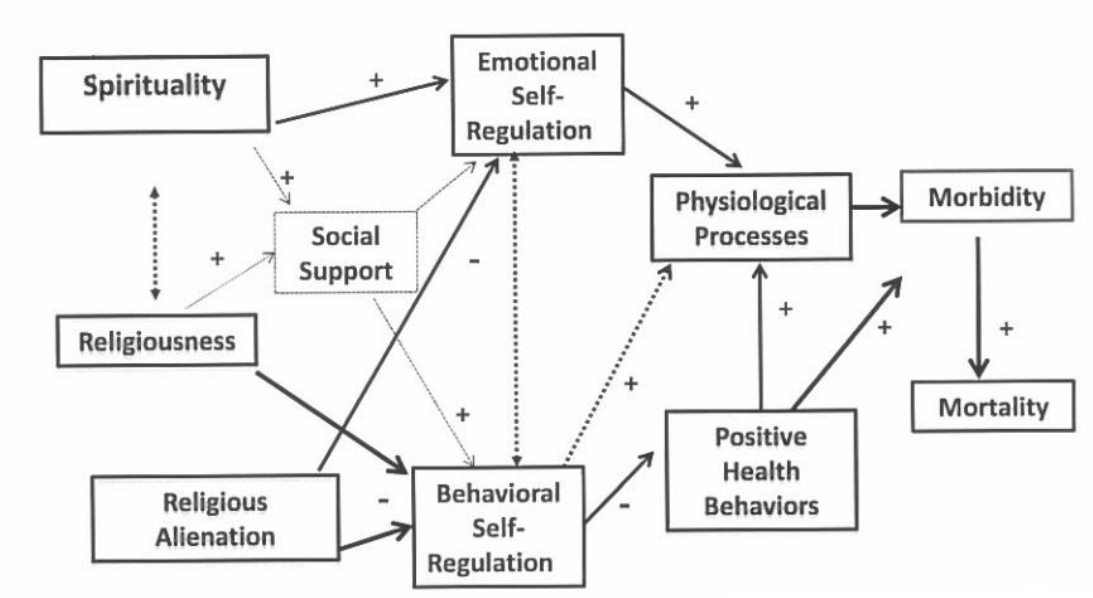
☐ I disagree

Appendix 13

Models on the reported relationship between spirituality and health

The first model presented is from Aldwin et al. (2014), who proposed the model of the differential impact of religiousness and spirituality on pathways to morbidity and mortality (model 1). It is useful for this research as it separates the effects of religion and spirituality in the context of healthcare.

Model 1: Differential Impact of Religiousness and Spirituality on Pathways to Morbidity and Mortality



Aldwin et al. (2014, p.21) 'Differing Pathways between Religiousness, Spirituality and Health: A self-Regulation Perspective' in *Psychology of Religion and Spirituality*, 6(1) pp.9-21.

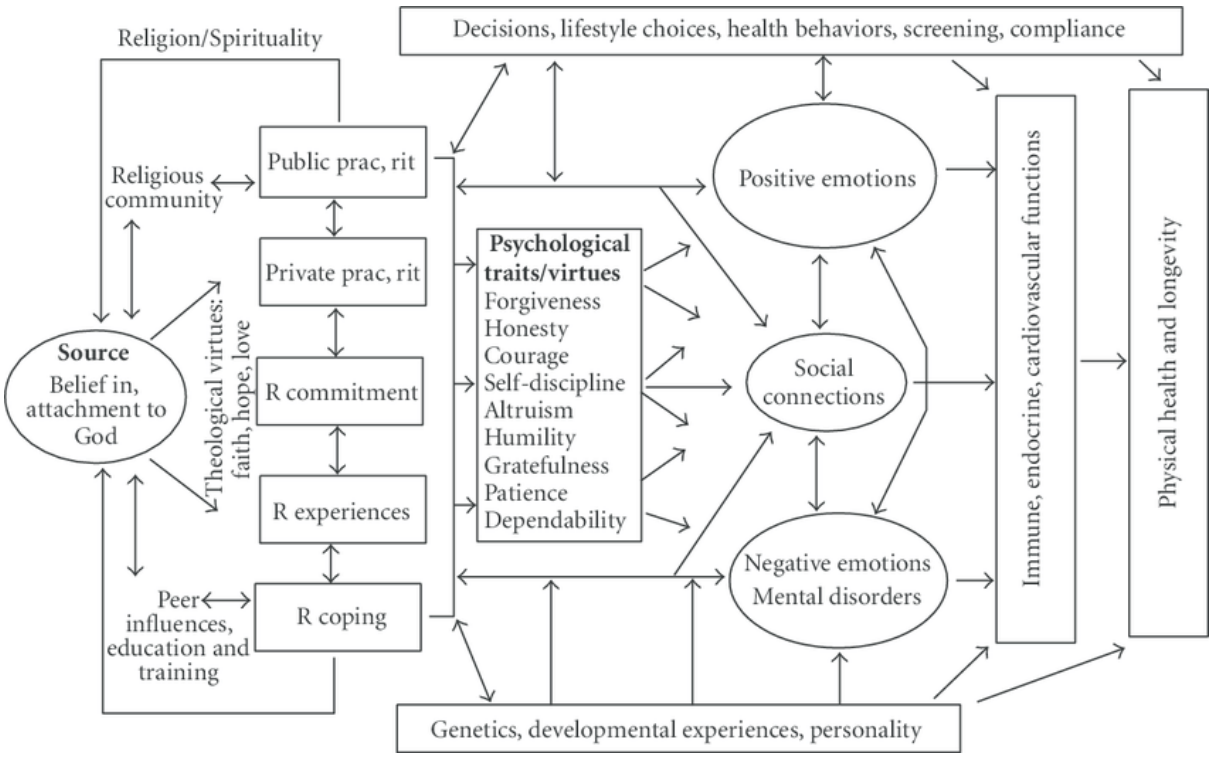
This model was developed based on self-regulation theory, which is the idea that an individual is an active agent who engages in a dynamic process of first assessing health threats and then using problem-solving strategies to address them (Aldwin et al., 2014). This model was developed to distinguish between religiousness and spirituality, and to achieve a better delineation of health behaviour to help inform and improve clinical applications and interventions in the USA.

Upon further analysis, Aldwin et al. (2014) claim that while religiousness and spirituality might be related (as shown by the dashed arrow in model 1), they have different pathways to health outcomes. Aldwin et al. (2014) state that spirituality and religion have different effects on people's morbidity and

mortality. Religiousness was strongly associated with better health behaviour habits, including lower smoking and alcohol consumption and a higher likelihood of medical screenings, but was only weakly related to biological factors. However, measures of spirituality were more strongly linked to blood pressure, cardiac reactivity, immune factors, and disease progression. The limitations of this model are that it is theoretical, and its purpose is to be more illustrative than comprehensive. It also focuses on morbidity and mortality; hence, it excludes other aspects of health by default. However, this research is useful as it highlights the different reported effects spirituality and religion can have on a person's health.

Koenig and colleagues have also created several models over the years to show the ways in which religion and spirituality may potentially affect people's physical and mental health. Two of the models most relevant to this study are presented in model 2 'Theoretical Model of Causal Pathways for Physical Health for Western monotheistic religions (Christianity, Judaism, and Islam)' and model 3 'Theoretical Model of Causal Pathways for Physical Health for Secular Humanism'.

Model 2: Theoretical Model of Causal Pathways for Physical Health



Key:
R = Religious
Prac = Practice
Ri t= Rituals

Image from Koenig, King and Carson (2012, p.587) *Handbook of Religion and Health.*

Model 2 was developed as a hypothetical model of how Western religion can potentially impact people's physical health. As highlighted, belief in attachment to God can be explained by theological virtues such as faith in God, hope in God, and love for God. This model illustrates that religion provides resources for coping with stress that can increase the frequency of positive emotions and reduce the likelihood that stress will cause emotional disorders, such as depression, anxiety disorder, suicide, and substance abuse. In this model, religious coping resources are seen as including powerful cognitions (such as firmly held beliefs) that give meaning to difficult life circumstances and provide a sense of purpose (Koenig, King and Carson, 2012).

Koenig, King and Carson (2012) argue that Western religions tend to offer an optimistic worldview that may involve the existence of a personal transcendental force that loves and cares about humans and responds to their needs. These cognitions also give a subjective sense of control over events. For example, if God is in control, they can influence circumstances, and if they can be influenced by prayer, then prayer by the individual may positively impact the situation (Koenig, King and Carson, 2012, p.587). Some of these aspects could be spiritual attributes, such as 'commitment' and 'connection' or the notion of spiritual practices having a similar effect.

The second model that Koenig, King and Carson have developed, which is also relevant to this research, is presented in model 3. As demonstrated, this model (model 3), on the humanistic worldview, gives rise to positive psychological traits (human virtues) and affects lifestyle choices and health behaviours, which in turn influence positive emotions and social connections (Koenig, King and Carson, 2012, p.592). Secular Humanism rejects the supernatural and any religious or spiritual beliefs or practices related to it (2012, p.592). The model suggests it can affect people's physical health and longevity, similarly to model 2.

Model 3: Theoretical Model of Causal Pathways for Physical Health for Secular Humanism

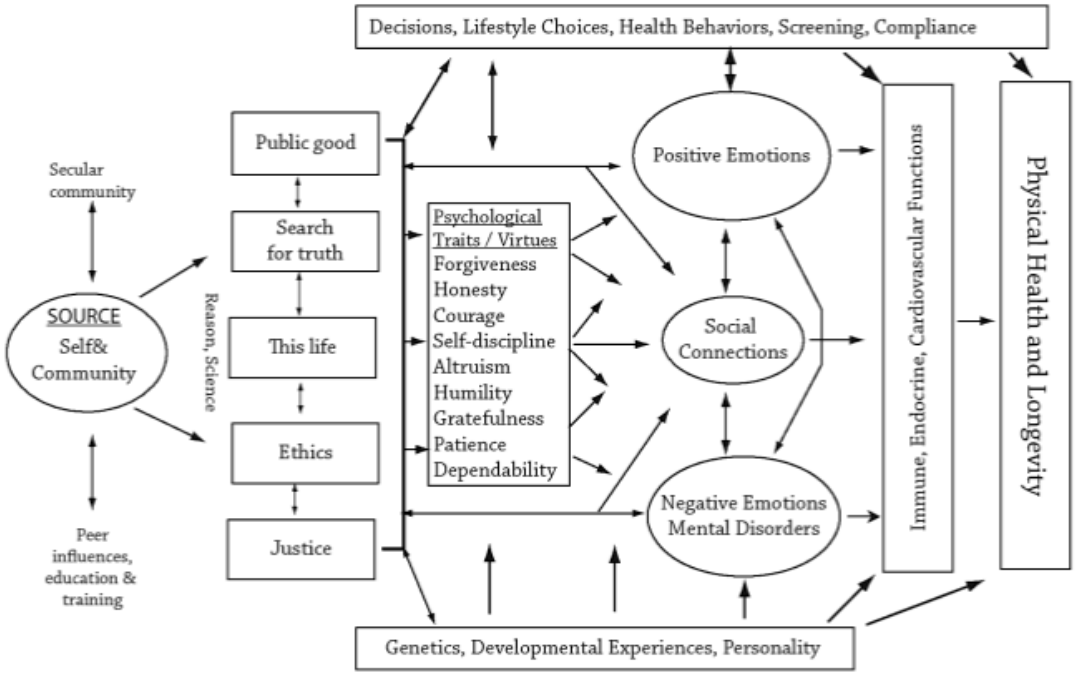


Image from Koenig, King and Carson (2012, p.592) *Handbook of Religion and Health.*

Model 3 is a comparable image to model 2, as it similarly goes from left to right. However, one difference between the models is that model 3 has 'the emphasis on science and medicine, which could lead to greater efforts at disease prevention and perhaps better health behaviours, since the physical body is all there really is this belief system' (Koenig, King and Carson, 2012, p.593). Koenig, King and Carson (2012, p.593) state that in relation to this belief system, 'the strong ethical system and demand for justice may also serve to enhance the community relations and build social capital, which affects health in a positive manner'.

The models presented in both models 2 and 3 are useful because they provide a framework for discussion and provide a detailed illustrative model of the potential relationship between belief and aspects of health. However, upon analysis there are limitations. Both models only focused on one aspect of health and not all dimensions of health, they are only theoretical (although they came from the foundations of empirical study) and thus not measurable within empirical healthcare research. Koenig, King and Carson`s (2012) work has also been criticised for emphasising medical perspectives and effects on individuals rather than communities (Oman, 2018, p.7). Furthermore, several have challenged Koenig's and his colleagues' research, voicing concerns regarding the methodology of many studies and the conclusions drawn from them (Berry, 2005; Sloan and Bagiella, 2002).

Appendix 14

Personal reflections

I have now conducted and written up all my research, and at the final stage, I reflected on my experience of being a PhD student and the whole research process. I decided the best way to do this was to use Bassot's (2016) Integrated Reflective Cycle to support my reflexivity. This approach was chosen because it is considered a robust reflection framework to enable an in-depth and professional judgement (Bassot, 2015). This cycle is made up of four stages:

1. Experience: Describe the experience.
2. Reflection on Action: Look at the experience and identify what went well and what could be improved. It is where you explore your thoughts, feelings and assumptions and ask yourself why.
3. Theory: Think about the experience in a larger context of professional literature and your own learning and personal experience.
4. Preparation: Using your reflection to prepare yourself for future experiences.

Experience

Overall, I have enjoyed my experience of being a PhD student and becoming more knowledgeable in this topic area. I have achieved satisfaction of my personal curiosity, and above all, the opportunity of having my work published. The experience of conducting an in-depth literature review to guide my research questions was very helpful to provide insights into this area. I started my research journey, thinking I was going to focus more on disability and a particular religion, but instead, I focused on health and those who identify as SBNR.

This experience and knowledge allowed me to go forward and work out my aims and objectives as well as the best way to collect and analyse the data. In relation to this study's design, one of the critical aspects of this research was using a mixed methods approach, which enabled convergent triangulation, so a wide range of data could be collected and further investigated. The results from all the data have contributed to more informed recommendations being made. Triangulation forced me to look at the data in the broadest possible manner, and thematic analysis was used to critically scrutinise the data, instead of merely accepting findings from one methodological paradigm. Together with the previous supporting literature, these methodological approaches enabled this study to be made more rigorous.

I collected the questionnaire data first. I found sharing my questionnaire online such an exciting experience, and I felt like I had a great deal of support from people on social media, which helped to boost my morale. I also enjoyed the experience of conducting the interviews and listening to the participants' responses. Before I began the interviews with the participants, I had no idea how they would respond, and my skills of interviewing about this topic were developed throughout the process. I have acquired many new skills, such as improved communication and computer-based skills, and I would now consider myself competent at using computer software to analyse data.

Once I collected the data and started looking at the findings, I felt as if my research question had shifted: the results I thought I was going to find, such as engagement in spiritual practices and differences in demographic factors, did not actually emerge in this study. One of the most significant aspects of this research for me personally, was having the privilege of hearing so many people's thoughts and opinions on the subject matter, which was challenging for many to put into words.

From my perspective, it took a great deal of time to obtain a wide range of people's thoughts and experiences, and for the research to be taken seriously within the field of Public Health. At the same time, one of the difficulties I came across was analysing such large data sets, and as a result, I felt frustrated and lost at times, particularly with regards to the quantitative data and knowing which test to run or not run. To deal with this issue, I asked myself how useful this data was to this research, and in answering the research question and addressing the objectives of the study. My supervisors helped to guide me.

There was some disruption during my PhD. Unfortunately, in the beginning, supervision at times was disjointed due to some of my supervisors leaving the university. However, with every new supervisor came different ideas, knowledge and experience. I tried to use this as a positive and fortunately finished with some great supervisors, but at times it did cause me some stress and anxiety. The experience has been very challenging mentally, particularly the highs and lows of conducting this research. I also struggled with the editing stage of the PhD. This was partly due to my struggles of being dyslexic and not being able to see errors in my own work. It took me a long time to find my 'voice' and to increase my self-belief and self-confidence.

One of the highlights of being a PhD student was that it enabled me to teach and mentor undergraduates, for which I have developed such a passion. This has given me the confidence to now teach at a higher level, (for example, Masters and PhD), and to present my research at both national and international conferences. I have gained a great deal of knowledge and most importantly, new insights into the world of spirituality and health. I now want to go and conduct further research and implement my findings into practice.

My PhD journey has inspired me to become more spiritual. I bought a motorhome, travelled, and started engaging in so many more spiritual activities than before embarking on studying this topic. I am so glad I saw this journey through to the end. It has given me confidence, determination and courage, and above all, it reminded me of how resilient I am.

Reflection on Action

Upon reflection, I was trying to provide insight into a complex topic. The literature review helped to reveal where the gaps were in the research. A complicated methodology was used, but I was confident it would provide much more insight than other methods. Reflecting on the data collection methods helped me realise that they were an excellent way to collect large amounts of useful data. This approach was taken as I believed it was the right approach to use, based on the literature review. However, I underestimated the size of the data set generated; consequently, the time to complete the whole research project took much longer than anticipated. This project took a great deal of hard work and commitment. There is also the notion of *'you only know what you know',* and at the time, I thought the decisions I made were the correct ones to provide insight into my thesis topic, and this changed as I went through the PhD journey and developed my confidence, as well as my research skills.

Theory

Writing a PhD thesis has meant that I am now able to incorporate new methods of communication and work within professional boundaries, building relationships quickly to meet the desired outcome. This is common for people who reflect on their actions (Girot, 2002; Johns, 2002). I have tried to incorporate reflection into this research and acknowledge my own beliefs and values. I can now deal better with confrontational situations and prevent them from arising (Mackay, 2007) by changing how I react. There are four well-known theories about how people learn. These include:

1. Behaviourism: posits that learning is a response to external stimuli.

2. Cognitivism: posits that learning is a process of acquiring and storing information.

3. Constructivism: posits that learning is a process of building an understanding.

4. Connectivism: posits that learning is a process of connecting nodes or information sources; it is dependent upon technology and recognises the role the Internet plays in helping people expand their learning.

(Roblyer and Doering, 2010; Siemens, 2005; Smith, 2003).

Within my research process, I feel I have fully engaged in all these different learning methods, as I have a pragmatic approach to research. I also have a pragmatic approach to learning and believe that throughout my journey, I have engaged with all these different learning processes, particularly as being a researcher requires so many different skills (Gardner, 2010; Schmidt and Hansson, 2018; Silvera, Laeng and Dahl, 2003; Thomas, 2004; Winston, and Fields, 2003). The theory around the learning of PhD students also suggests that doctoral student wellbeing is an important matter that shapes the wellbeing of academics throughout their careers. Given that wellbeing has been found to be closely related to employee productivity and efficiency, strategies associated with maintaining wellbeing during PhD studies may be crucial for higher education and its outcomes (Schmidt and Hansson, 2018).

Teaching and mentoring other students have been beneficial for my self-growth. Research suggests that this mentoring relationship may also foster interest in graduate training, as the PhD student can gain valuable experience mentoring a less-experienced student with the support of a faculty mentor (Abbott-Anderson, Gilmore-Bykovskyi and Lyles, 2016; Kessler and Alverson, 2014); thus creating a "win-win" situation for both the mentee, myself and other academic workloads.

Preparation

If I was going to conduct another research study on this topic, I would keep in mind the experiences I had during my PhD and ask other researchers for their own research experience, which may be relevant to further research. In relation to the topic I was investigating, I would conduct further research on how potentially how spirituality is reported to influence people's health within Public Health. Therefore, many other health professionals can move forward and understand what is best for their service users (Colyer, Helme and Jones, 2005).

Summary

When I reflect on the start of this course and my general academic journey, I am aware of the vast amount of knowledge and skills that I have gained over the years; this has led to a change in both my professional and personal practice. I am also aware that there is still much more to learn, and having some knowledge means that I am acutely aware of what is still to be discovered. I also believe that this thesis has been instrumental in changing my own perception of spirituality and health. This also helped me to 'find' and even develop my own identity; I will use this to support my future students,

work colleagues and further develop myself. However, I know teaching says something about my own values towards education and the philosophies I hold as a person (Cunningham, 2015; Sachs, 2001).

As the thesis ends, this is only the beginning of my research about the impact that spirituality may have on people's health. I will continue to explore research about this topic, and I will meet more people with similar interests. In the future, I want to use my knowledge about the current study's limitations to develop a stronger research design (where resources allow). In addition, I would like to apply for funding for a longer more in-depth study, to be able to conduct research over a more extended period.