**Religion, Spirituality and Personal Recovery among Forensic Patients**

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**Declarations of Interest**

None

**Abstract**

Purpose

Religion and spirituality are well-researched concepts within the field of psychology and mental health yet they have rarely been researched in high secure services within the UK. Research in mental health and prison contexts suggests benefits of religion/spirituality to coping, social support, self-worth, symptoms of depression and anxiety, and behavioural infractions. This study investigated the role of religion/spirituality in high secure service users’ personal recovery.

Design/method/approach

Semi-structured interviews were carried out with 13 male patients in a high secure hospital, with primary diagnoses of mental illness (n=11) or personality disorder (n=2). Participants were from a range of religious/spiritual backgrounds and were asked about how their beliefs impact their recovery and care pathways within the hospital. Data were analysed using Interpretative Phenomenological Analysis.

Findings

Three superordinate themes were identified: ‘religion and spirituality as providing a framework for recovery’, ‘religion and spirituality as offering key ingredients in the recovery process’, and ‘barriers to recovery through religion/spirituality’. The first two themes highlight some of the positive aspects that aid participants’ recovery. The third theme reported hindrances in participants’ religious/spiritual practices and beliefs. Each theme is discussed with reference to sub-themes and illustrative excerpts.

Practical implications

Religion/spirituality might support therapeutic engagement for some service users and staff could be active in their enquiry of the value that patients place on the personal meaning of this for their life.

Originality/value

For the participants in this study, religion/spirituality supported the principles of recovery, in having an identity separate from illness or offender, promoting hope, agency, and personal meaning.

**Keywords**

Religion, spirituality, recovery, forensic mental health, high secure service, therapeutic engagement

**Introduction**

Religion and spirituality are related constructs that can be integrated into daily life (Hill et al., 2000; Hill & Pargament, 2008). As an individual and institutional construct (Hill & Pargament, 2008), religion is defined as a personal belief in God or higher power and a dedication to a belief system and practices traditional to a group of individuals (Hill & Pargament, 2008). Spirituality has been defined as those issues of personal identity and experience that motivates individuals outside of their day-to-day lives (Galanter, Dermatis, Talbot, McMahon & Alexander, 2011), a belief in a higher being and sense of connectedness (e.g. Cornah, 2006), but can be experienced within an organised religious context. Both religion and spirituality have a positive impact on individuals’ lives. Research from non-forensic contexts indicates that religion and spirituality provide an individual with social support (Bradley, 1995, Ellinson & George, 1994), act as a coping strategy in response to stressful life events (Clear, Hardyman, Stout, Lucken and Dammer, 2000; Pargament, 2001; Park 2005) and emotions and daily difficulties (Hefti, 2011; Longo & Peterson, 2002), give an individual a sense of meaning and self-worth (Hefti, 2011; Mohr & Huguelet, 2004; Steger & Frazier, 2005), and have positive implications for physical and mental health (George, Larson, Koenig & McCullough, 2000; Miller & Thoresen, 2003; Seybold & Hill, 2001).

In terms of therapeutic engagement, patients with religious/spiritual beliefs thought their religious practices were compatible with treatment (Huguelet, Mohr, Borras, Gillieron & Brandt, 2006) and patients in religious and spiritual psychotherapies showed greater improvement than those in alternative therapies on both spiritual and psychological outcomes (Smith, Bartz & Richards, 2007; Worthington, Hook, Davis & McDaniel, 2010). However, patients with a religious identity were thought to be less likely to disclose their personal beliefs to non-religious clinicians for fear of being misunderstood (Huguelet et al., 2006).

There is, however, evidence to suggest that holding a religious identity can have a detrimental impact on mental health. Patients who felt rejected by their faith, burdened by spiritual activities and demoralised by their beliefs (Mohr & Huguelet, 2004) were vulnerable to symptoms of anxiety, depression and suicidal ideation (Rosmarin, Bigda-Peyton, Ongur, Pargament & Bjorgvinsson, 2013). The evidence on religion/spirituality and medication compliance is equivocal. Religion has been articulated as a reason for declining prescribed medication in some clinical samples (Borras, Mohr, Brandt, Gillieron, Eytan & Huguelet, 2007), but enhanced compliance with antipsychotic medication among people who use religion to cope (Kirov, Kemp, Kirov & David, 1998). Furthermore, some religious/spiritual beliefs might offer interpretations of mental health problems in ways that are not aligned with a medical model, with implications for barriers to engagement in dominant Western models of assessment and treatment of mental health (e.g. Department of Health, 2009).

Research from prison settings suggests that religion and spirituality have a positive role in offender rehabilitation. For example, religious involvement is associated with less numerous infractions (O’Connor & Perryclear, 2002) and reduced arguments and violence (Eytan, 2011), and is thought to support relapse prevention (Clear et al., 2000). Using religion as a moral framework from which prisoners rebuild their lives (Spalek & El-Hassan, 2007), as well as identifying with positive role models in order to keep focus (Kerley & Copes, 2009), may be mechanisms underpinning this reduction in risk. In terms of mental health and engagement, prisoners with a religious/spiritual identity show fewer symptoms of depression and a lower risk of suicide (Mandhoujh, Aubin, Amirouche, Perroud and Huguelet, 2014) than their non-religious/spiritual counterparts. Inner peace, altruism and a sense of respect for others have also been reported in religious prisoners (Mandhouj et al, 2014).

The social dimension of religion and spirituality (rather than the cognitive, affective and behavioural dimensions) has been found to be highly important to forensic populations (van Uden & Pieper, 2000), including people reintegrating into the community from correctional services (e.g. Stansfield, Mowen, O’Connor & Boman, 2017). Religiously converted prisoners were found to remain focused and inspired through social support from others following their religion (Kerley & Copes, 2009), and reported a sense of belonging (Spalek and El-Hassan, 2007). This seems to be important for people who, by virtue of their offending behaviour, are excluded socially or physically from society. Furthermore, religion has been found to provide a new social identity, an alternative to the label of ‘offender’, giving meaning and purpose to a prisoner’s life, and to their sentence (Maruna, Wilson and Curran, 2006).

The experience of social exclusion extends further to forensic mental health patients, of whom many experience stigma of psychiatric diagnosis and exclusion due to offending (e.g. West, Mulay, DeLuca, O’Donovan & Yanos, 2018). Within forensic mental health services, the recovery approach has been central to promoting social inclusion, social and personal support, and maintaining hope (Deegan, 1998; Shepherd, Boardman & Slade, 2008; Slade, 2009), and it has long been argued that religion and spirituality might support these objectives in forensic mental health care (e.g. Cox and Grounds, 1991). The recovery approach involves discovery/re-discovery of a personal identity separate from illness or disability, in which self-management is encouraged and facilitated. Principles of recovery include engagement with a meaningful and satisfying life, a focus on health, strength and wellness, agency, peer support, and the co-production (patient, professional) of discovery towards recovery (Shepherd et al., 2008).

There is a lack of studies that have examined the role of religion and spirituality for high secure service users, forensic mental health patients who present with needs pertaining to serious risk of harm to self and/or others and who have serious mental health problems. In high secure services, issues of risk, management, treatment, and safety need to be balanced carefully with agency and choice in services that promote the recovery principles. The lack of research on religion/spirituality in these services is despite spiritual needs having been identified as one of the eight domains of need that deliver individual change, risk reduction and mental health recovery/discovery in high secure service users (Glorney et al., 2010). One study in an English high secure hospital found that there was high demand among patients for teachings and practice provision in the Muslim faith, with solidarity of difference being a possible reason among this minority religious group (Saleem, Treasaden & Puri, 2014). However, there was no exploration of the personal meanings of religion/spirituality to the service users, nor the possible role of this in support of recovery. It might be that the benefits of religion/spirituality to non-forensic patients and prisoners hold relevance to forensic mental health patients also, but there might also be key differences. For example, among a consecutive sample of forensic patients admitted to a multi-level service in Canada, higher self-reported engagement with religious and spiritual practice correlated with lower depression and anxiety and higher life satisfaction (Mela, Marcoux, Baetz, Griffin, Anjelski, & Deqiang, 2008). The outcomes were more pronounced among the forensic mental health patients than among previous research with prisoners, leading the authors to conclude that the secure environment might be influential (Mela et al., 2008). This adds support to the need to understand – from the perspectives of forensic mental health patients – the role of religion/spirituality in their personal recovery.

This study aimed to explore the personal meaning and importance of high secure service users’ religious and spiritual beliefs in terms of their recovery. It also aimed to identify potential difficulties patients were faced with in the hospital when they tried to meet their religious and/or spiritual needs.

**Method**

***Design and Ethical Approvals***

A semi-structured interview design within a qualitative methodological approach was employed. Favourable ethical opinion was provided by West London Mental Health NHS Trust Research and Development Committee, the North East Research Ethics Proportionate Review Sub-Committee, and the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.

***Participants***

The recruitment site was a high secure hospital for male patients with mental illness and/or personality disorder in the south east of England. Patients with a self-identified religious and/or spiritual identity at the point of admission to the hospital, as indexed by the hospital chaplaincy service, were identified as potential participants. An implication of this approach was that some patients no longer self-identified as religious or spiritual, some had converted to another religion, and others self-identified as agnostic but spiritual. A total of 57 patients on rehabilitation wards were invited to participate in the research. Patients on admission, intensive and enhanced care wards were not identified to participate due to risk, security issues and an increased likelihood of those patients having a lack of capacity to consent to participate, due to the nature of the wards.

Potential participants were approached by the researchers on the ward and given an information sheet and verbal information about the study. Thirteen participants agreed to interview, 11 with a primary diagnosis of mental illness and two with a primary diagnosis of personality disorder.

Five men identified their ethnicity as White British, five as Black African, two as White and Black Caribbean mixed and one as Indian. Participants’ ages ranged from 20 to 67 years (M=36 years). Five participants held the same religious and/or spiritual beliefs since birth whereas eight participants converted from other religions. However, two of the participants who held their beliefs since birth acknowledged that their beliefs became stronger since being in the hospital. Participants’ clinical and religious/spiritual characteristics are presented in Table 1.

***Procedure and Materials***

The semi-structured interview schedule was developed following reviews of the literature on religion/spirituality and recovery, and in line with good practice in developing interview schedules (Smith & Osborn, 2015). Multidisciplinary teams provided indications of patient capacity to consent to participation, prior to patients being approached by the research team. Interviews were conducted by two assistant psychologists who were trained in conducting semi-structured interviews and supervised by the lead researcher at the hospital. Interviews were held at a convenient time in an interview room on the patient’s ward, and lasted between 15 and 60 minutes, until participants did not have anything further to add. Participants were debriefed and thanked for their participation. All interviews were audio recorded, transcribed verbatim, and pseudonyms applied throughout.

Table 1. Religious/spiritual and clinical characteristics of participants

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pseudonym | Primary diagnosis\* | Religious/spiritual orientation | Duration orientation | Previous orientation |
| Andrew | MI | Jehovah’s Witness | 20 years | Catholic |
| Carl | MI | Muslim | Since birth | Muslim |
| Charles | MI | Church of England | Since birth | Church of England |
| Daniel | MI | Agnostic | 5 years | Agnostic |
| Edward | PD | Muslim | Since birth | Muslim |
| George | MI | Church of England | Since birth | Church of England |
| Henry | PD | Church of England | 20 years | Agnostic |
| John | MI | Buddhist | 20 years | Christian |
| Michael | MI | Muslim | 13 years | Christian |
| Peter | MI | Agnostic | 17 years | Christian |
| Robert | MI | Muslim | Since birth | Muslim |
| Thomas | MI | Agnostic | 41 years | Christian, Muslim |
| William | MI | Muslim | 6 months | Christian |

\* MI – Mental Illness; PD – Personality Disorder

***Analytic Approach***

Interpretative Phenomenological Analysis (IPA) was employed to produce an in-depth exploration of the personal lived experience of the individual. IPA is formed of three key areas of philosophy of knowledge; phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009). The IPA research approach is seen as involving a double hermeneutic where the participant is trying to make sense of their world while concurrently the researcher is trying to understand how the participant is making sense of their world. The IPA researcher must interpret the person’s mental and emotional state when they are struggling to express what they are thinking and feeling (Smith & Osborn, 2015). All transcripts were analysed independently by two members of the research team and agreement on themes was achieved through discussion of data interpretation.

**Results**

Three super-ordinate themes and associated sub-themes were interpreted of the data and are discussed in turn, below: *Religion and Spirituality as Providing a Framework for Recovery*, *Religion and Spirituality as Offering Key Ingredients in the Recovery Process*, and *Barriers to Recovery Through Religion and Spirituality.*

***Religion and Spirituality as Providing a Framework for Recovery***

This theme illustrated how the standards set by an individual’s religion and/or spirituality helped to provide them with skills and motivation to achieve personal life goals and work towards recovery. Sub-themes comprised *Good Morals by which to Live*, *Guidance and Direction from Role Models*, *Increased Self-Efficacy,* and *Redemption Through an Afterlife*, and are discussed in turn.

*Good Morals by Which to Live*

Religion/spirituality offers scripts and rules that provide participants with good morals by which to live their life. This contributes towards their framework for recovery by guiding them to cooperate and communicate more positively with others, including staff and patients. Peter speaks of *“doing to others as I would like to be done to myself. I believe in being fair to people…”*, which might increase social support, inclusion, and offer psychological benefits when he helps others. Living by such morals might reduce an individual’s level of risk, as articulated by Thomas: *“The Ten Commandments tell me I must not steal, must not kill, mustn’t do a lot of different things, and if follow those, then I won’t, I won’t relapse, ‘cos a relapse for me would constitute violence”.* Following these rules has implications for a participants’ recovery beyond the hospital setting; they are aware that living by these morals is necessary in order to be integrated back in to society: *“it keeps me in society, sort of thing. Being accepted back in to society…”* (Charles).

*Guidance and Direction from Role Models*

Role models were identified as religious figures, communities, and teachings, and seemed to be important to recovery in the context of enhancing problem-solving strategies and coping skills. For example, religious figures and communities guided participants towards making the right decisions in life: *“I take Jesus’ example in a lot of cases, what he would have done in certain circumstances”* (Andrew); “*It’s like with any community, if, if the community’s bad then you end up doing bad, but if the community’s good, it has a good impact on your life and you end up going doing good stuff”* (Edward).Religious teachings, such as The Ten Commandments, “*…guide you, it’s sort of a foundation*” (Peter).

*Increased Self-Efficacy*

Religion/spirituality reinforced participants’ beliefs that they can achieve their goals through continued practice, and it is possible that such skills would be transferable to other domains where belief in one’s ability to succeed is important, for example, recovery: “*I am far from saying I have accomplished the final attainment, extremely far…all I can say is that I am practicing, and that is all I can do”* (John). Religion also offered a framework within which to challenge the self, succeed with behaviour change, and gain a sense of achievement: “*I ain’t fasted before, never fasted in my life. But now when I done Ramadan I thought ‘yeah, that’s good’…*” (William).

*Redemption Through an Afterlife*

Participants spoke about belief in an afterlife and explained that committing to their religious/spiritual practices and living by good morals means that they will go to Heaven in the afterlife and be redeemed of sins: *“people who give more are the people who will receive more in the future [the afterlife], so the more I give away, the more I get”* (John). This was personally meaningful to participants because of the shame and guilt carried from their offending behaviour and their belief in judgment in the afterlife: “…*when I was younger I was afraid of dying when I got older, but when you have inner peace and belief, that, that fear’s not there anymore. You’ve got something to believe in…*” (George). Furthermore, participants were committed to practice because *“…you don’t know when you’re going to get to leave this, leave this life…”* (Robert).However, Charles was of the view that he needed to forgive himself before other people would forgive and accept him, that religion was unable to rid him of sins: *“I’ve gotta be remorseful of what I’ve done … it’s not a very nice thing to do”*. It might be that belief in redemption is a mechanism to support acceptance of offending behaviour, reconciling the offender part of self with other parts of identity, and manage feelings of guilt and shame. Rather than undermining feelings of remorse and acceptance, belief in religious/spiritual redemption perhaps supports this.

***Religion and Spirituality as Offering Key Ingredients in the Recovery Process***

This theme encapsulated benefits of religion and spirituality for the recovery process and comprised three sub-themes: *Psychological and Behavioural Benefits*,

*Social Support and Inclusion*, and *Alternative Identity.*

*Psychological and Behavioural Benefits*

Through religion/spirituality, participants gained strength, improved coping and calmness, all relevant to recovery and the process of risk reduction: *“… to cope, you don’t, you let things just wash off you. You don’t get worried by things…”* (Andrew). Participants thought religion had *“calmed me, like, spiritually. Kind of relaxed me, humbled me”* (William), helped *“when medication can’t help, where therapies can’t help”* (John), and offered resilience if *“I stick to my faith, it makes me stronger…”* (Robert).

Participants also experienced improved mood and mental health. Through prayer, Carl said *“the more I prayed, the less my voice got … I was hearing very, very, very few voices, you know, not as many as I used to hear before. So, it’s quite good…”*. Improvements in mental wellbeing did not go unnoticed by other people, and through teachings and mindfulness, John reflected “*…my teacher says…‘you came to me in the depths of, of, of, great depression, and great, great pain, and you have seen yourself through it’ …if you pacify emotional disturbance then, naturally, the ill feeling goes and happiness remains and you can be well … become well mentally, which is recovery isn’t it?”*.

The benefits were not wholly located with religion/spirituality but were spoken about in the context of a mutually beneficial relationship with medication and psychological therapies. For example, Edward valued medication and commented *“I feel like if I stop praying, if I stop taking my medication, I’ll stop, I feel like something bad is going to happen to me”.* Henry commented that religion/spirituality *“…lowers risk and it stops me from doing things”* but *“I think therapy and other things generally help with, with risk”*.

*Social Support and Inclusion*

Through shared beliefs, participants felt “*we’re a community here…*”(Edward) and believed they were *“…accepted by other people as well, if people accept me then I’m part of that, of that big family that I like to call it”* (Henry). The inclusivity of a “big family” suggests that religion and spirituality offer social support beyond the hospital setting, and this might enhance integration into communities. However, feeling included was important not just to feel connected to or accepted by other people but also to support risk reduction. Participants spoke of feeling like an outsider as a contributing factor to their offending behaviour, and the collective identity of religion/spirituality as supporting inclusion: *“you meet new people at church, don’t ya? All the same religion so you can relate to people better. Less chance I’ll get into a punch up”* (Charles).

Daniel explained the benefits of social support from his religion by stating “*you’re liked, innit, you’re not on your own no more. You got meaning, you got people to support you…”*, and these experiences might support his psychological wellbeing. The social support of a religious/spiritual identity extended to patient/staff relationships: *“my old primary nurse, he came from a Rastafarian family… so we would talk about our individual beliefs…we had quite a good relationship”* (Thomas). In this example, the sharing of boundaried but personally meaningful beliefs supported engagement and working relationships between a patient and staff member, which had a positive impact on his care pathway.

*Alternative Identity*

Religion/spirituality allowed participants to embrace an identity beyond that of patient or offender, and linked to a sense of comfort: *“I haven’t got the general pains that most of the patients have got…I haven’t got such difficult pains because … I’ve got a sense of refuge”* (John). Henry found it difficult to reconcile himself with his identity as a patient, so his religious/spiritual identity was critical to his sense of positive self: “*…it’s a part of me that I think, ‘yeah, ok, that’s a good part of me’, you know, and it makes me feel good about myself…”.*

Having an alternative identity and engaging in activities aligned with religion/spirituality also had practical benefits in facilitating time off the ward, so alleviating boredom and engaging in positive activities: “*I’m living like a bum’s life, you call it. A loafer’s life…I want to occupy my mind so I go to Islam classes”* (William). This was also motivation for some participants to engage in religion/spirituality. Henry commented *“it started off when I was in prison, with my religion, because I used to go to chapel to get off the wing on a Sunday morning … the more I went … and I sort of starting believing in God and Jesus … it plays a big part in my life now”.*

***Barriers to Recovery Through Religion and Spirituality***

This addresses some of the problems - which might hinder the recovery process - participants were faced with as a result of their religious or spiritual identity, and included *Stigma and Religion*, and *Hospital as a Hindrance for Religious/ Spiritual Practices*.

*Stigma and Religion*

Most participants reported feeling judged because of their religious beliefs. This was particularly common among Muslim participants, some of whom had experiences of people trying to *“paint this picture that we’re all murderers, that we’re all terrorists, you know, we all wanna blow things up, but that’s not the case, you know”* (Carl). Although still practicing Islam, this stigma created a barrier to recovery and inclusion because Carl felt negatively judged.

A religious identity was difficult to integrate with Henry’s sexual identity: “*I do sometimes struggle with being, believing in God because I’m gay. Umm, and the bible says certain things about that and I have had certain people come up to me and say ‘why are you believing in God if you’re gay?’”*. Although this has been a barrier for Henry in converting to Christianity, he is generally accepted in most modern churches and he believes that benefits he gains from his religion are worth the stigma attached to him as a gay Christian.

*Hospital as a Hindrance for Religious/Spiritual Practices*

As might be anticipated in a large, high secure hospital, there were organizational and structural challenges to the meeting of individual religious/spiritual needs. The physical confines of the hospital impacted on ability to practice: “*praying involves me having a bit of space to put my mat down and pray … and I haven’t got space like that in my room…”* (Carl). Participants were required to depend on staff in order to engage in religious and spiritual practices: *“I turned up at about twenty-five past four, when it’s supposed to start at four … they couldn’t get the staff to bring us across [to the chapel]”* (George). The limits of communication and lack of control over choice to practice were frustrating, with negative impact on mood: “*…it’s really disappointing when the Imam doesn’t show up… if he doesn’t come in on a Friday the congregation, you know, big congregation, the whole weekend is ruined”* (Robert). Both the physical environment and the systemic processes were barriers to participants’ full religious/spiritual practice and gaining the benefits for their recovery.

These experiences left participants feeling that their religious/spiritual needs were unimportant to staff and the hospital, so undermining personal value. Some participants felt that religion was *“one of the subjects that they have to be seen to be looking after … nobody knows when church is”* (George) and this left feelings of “*angry, um, just frustration really…at the ignorance, especially staff…”* (Michael).

**Discussion**

Through teachings and practice, religion/spirituality provided a moral and guiding framework to support the recovery of the high secure patient participants of this study. Benefits of religion/spirituality included the acquisition of an identity separate to those of offender or patient, a mechanism for social support and inclusion, and improved psychological wellbeing. Improvements in mental state and positive behaviour were experienced by participants as attributable to the mutual benefits of religion/spirituality with psychological therapies and medication. Negative aspects of religion/spirituality such as stigma and lack of knowledge among other people could be detrimental to recovery but the benefits seemed to outweigh the positives among participants in this study. Perhaps to be expected, there were practical challenges within a large, high secure hospital to being responsive to the religious/spiritual needs of participants (in line with Saleem et al., 2014) and these were experienced as devaluing the importance of religion/spirituality in recovery.

These findings are not out of line with benefits of religion and spirituality among prisoners and mental health patients, indicating that religion/spirituality can be a positive aspect of the experience of a forensic mental health patient. For example, Maruna et al. (2006) found that religion/spirituality offered a language and framework for forgiveness which could help lead to recovery, whilst Kerley and Copes (2009) found that individuals connected to positive role models in order to maintain focus. The value of religion/spirituality to enhancing self-efficacy links to increased hope for the future (Golsworthy & Coyle, 1999; Longo & Peterson, 2002; Maruna et al, 2006), relevant to recovery and instrumental in motivation for treatment and positive behaviour change (e.g. Deci & Ryan, 2000). There are also clear connections to social inclusion and personal support, through enhancing working relationships with staff, to feeling part of a group or community, with a commonality of faith or spirituality; again, there are well-established links here to recovery benefits (e.g. Tew, Ramon, Slade, Bird, Melton & Le Boutillier, 2012).

It might be that identifying the self within a religious/spiritual framework supported risk reduction for some participants, a finding that is in line with research by Spalek and El-Hassan (2007) who found that prisoners who gained meaning in their life through religion engaged in fewer problematic behaviours. Participants in this study referred to religion/spirituality as supporting the development of emotion regulation techniques, such as mindfulness and meditation, and improved emotion management is likely to support risk reduction. Furthermore, Kirov et al (1998) found that people with a diagnosed mental disorder used their religion as a way to cope with their diagnosis and it might be that religion/spirituality supports coping at times of stress (e.g. Pargament, 2001). Specific to the forensic mental health population – where there are key considerations of treatment and management of mental disorder alongside risk of serious harm – the participants in this study experienced religion/spirituality as sitting alongside formal interventions (including medication) for mental health restoration and risk reduction. This is contrary to research in non-forensic samples (e.g. Borras et al., 2007) but supports the literature on treatment compliance among people who use religion to cope (e.g. Kirov et al., 1998).

However, it might be that the self-management benefits of religion/spirituality identified by the participants in this study were located with identity separate from offender or patient. This is an important consideration, and one in line with the principle of having an identity separate from illness to support recovery, not least because high secure patients are defined by legal status with reference to severity of illness and dangerousness, and are socially excluded. Furthermore, the process of self-exploration, acceptance, and understanding is challenging for people who are trying to make sense of their mental health, the actions that led to them being detained in high secure care, and reconciling these – and new – parts of themselves into their self-concept and identity. Religion/spirituality might support an identity that is bounded by positivity and purpose for people about whom dominate narratives of illness and destruction, and this is critical to recovery and desistance. Feeling part of a broader community and having a sense of social inclusion through religion/spirituality might also overcome physical exclusion and stigma, and promote opportunities for connectedness and personal support, all of which are relevant to risk reduction and recovery.

***Limitations and Future Research***

The personal meanings of religion/spirituality as they applied to recovery were generated from a self-selecting sample of high secure patients who had indicated at the point of their admission to the hospital that they had a religious/spiritual orientation (more than a quarter of all hospital patients at the time of the study). Patients who were perhaps not so engaged with recovery were probably not included on the basis of the exclusion criteria of recruitment from wards where patients were likely to have limits to their capacity to consent to research participation. Therefore, the personal meanings of religion/spirituality for high secure patients who were not approached to take part or those who chose not to were not represented in this research. Although there are clear benefits of religion/spirituality to the recovery process of participants in this study, the role of religion/spirituality in supporting early engagement in change, recovery, and risk reduction remains an area for future research.

There are also limits to generalisation to diverse religious/spiritual orientations, and perhaps intersections with cultural beliefs. Participants did not represent all religious/spiritual orientations, nor cultures or ethnicities, and some participants had decided to change from one religious/spiritual framework to another. Furthermore, the self-identification with religious/spiritual labels might not reflect the experiences of other people who self-identified with the same label. For example, some participants who self-identified as agnostic but previously with specific religions also integrated religious teaching (e.g. The Ten Commandments) into their frameworks for recovery. Nonetheless, the value and personal meaning of religion/spirituality for participants in this study suggests that active enquiry about and taking an interest in religion/spirituality of all service users could support care pathway engagement and recovery. The importance of acknowledging religious/spiritual identity therapeutically has been articulated in previous research (Worthington et al., 2010), albeit there might be challenges to implementation in the context of boundary maintenance (e.g. Poole, Cook & Higgo, 2019).

The participant links between redemption and recovery probably warrant further research exploration. It might be that religion and spirituality offer a framework for confrontation – from the self and others – that supports the development of remorse, but also offers support (Cox, 1999; Cox & Grounds, 1991). This area of potential research is perhaps most compelling within forensic mental health services, where service users often grapple with trying to reconcile offending and illness identities, with narratives of remorse and reconciliation (e.g. Ferrito, Vetere, Adshead & Moore, 2012).

Furthermore, participants in this study spoke about some of the challenges to social inclusion of identifying with protected characteristics that – in the experience of the participants – were not congruent with the self-identified religious framework. Intersects between belief and protected characteristics possibly warrant further exploration in the context of the impact on the individual experience of stigma and exclusion and implications for recovery.

***Conclusion***

This was the first study of the personal meanings of religion/spirituality as applied to recovery among high secure service users. The findings revealed organisational challenges to supporting religious/spiritual practice needs, but benefits to such included self-identified risk reduction, personal value, increased psychological skills and resilience. Critically, and of specific relevance to forensic mental health service users, religion/spirituality offered an identity separate from that of offender and/or patient, and this seemed to be a key mechanism in support of the recovery process. Furthermore, the participants in this study experienced religion/spirituality as sitting alongside formal interventions (including medication) for mental health restoration and risk reduction. It is likely to be of benefit to patients and for mental health professionals in these services to continue to incorporate religion/spirituality into patient’s care pathways and recovery plans, being active in enquiry and support, in line with the Department of Health guidelines for working with religion and belief in the NHS (2009).

**Implications for Practice**

Recommendations for practice in working with people with a self-identified religious/spiritual identity with mental health problems can be found in Cornah (2016). Many of these recommendations hold relevance for forensic mental health service users but from hearing the voices of the participants in this study, the following recommendations specific to forensic mental health patients are made:

* Be active in enquiry about religion and spirituality, and try to build a picture of the personal meaning of this to the service user. Specifically:
  + Consider the personal meanings of religion and spirituality for coming to terms and coping with an offender and/or patient identity.
  + Consider the personal meanings of religion and spirituality for adjusting to, living within, and transitioning from forensic mental health care.
* Think about how the strengths of religion and spirituality for the service user can be incorporated into a care plan and support risk reduction and mental health restoration.
* Within professional and personal boundaries and competence, integrate religion and spirituality into therapeutic engagement. This can support development of professional relationships and engagement and maintenance in interventions to address risk reduction and mental health restoration.

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