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Religiosity and Psychological Well-Being in South Asian Muslim Women

by

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THESIS ABSTRACT

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RELIGIOSITY AND PSYCHOLOGICAL WELL-BEING IN SOUTH ASIAN MUSLIM WOMEN

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Religiosity has been researched in relation to psychological well-being through assessing cognitive and behavioural components of religion (e.g. prayer). The lack of consensus in defining and measuring religiosity is a complex matter. Different forms of religiosity are measured in relation to positive and negative psychological well-being. The literature review identifies orthodoxy and spirituality as two forms of religiosity. Research is examined in detail to establish how orthodoxy relates to negative well-being whereas, spirituality associates with positive well-being. Shame is a distressing emotion that involves negative evaluations of the self. Whereas, self-compassion is contrasted in that a positive relationship with the self is evident. Since shame and self-compassion are opposite constructs the prediction was that orthodoxy may relate to greater shame and lower self-compassion, whereas spirituality may associate with lower shame and greater self-compassion. The empirical research explored how both forms of religiosity; orthodoxy and spirituality relate to shame and self-compassion in South Asian (SA) Muslim women. The study's qualitative component explored the conceptualisation of shame. The results show that orthodoxy and spirituality are related yet distinct entities. Greater shame associates with lower self-compassion. No significant association was detected between shame and both forms of religiosity. Orthodoxy negatively correlated with self-compassion. That is a unique finding since this had never been researched previously. The qualitative component enabled the development of a process model for shame experience pertinent to this population that may be relevant for clinical practice. Implications of these findings, the study's limitations and recommendations for future research are debated.

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RELIGIOSITY IN SOUTH ASIAN MUSLIM WOMEN AND THEIR PRONENESS TO SHAME AND SELF-COMPASSION

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Abstract

Religiosity is a psychological construct involving cognitive, emotional, behavioural and motivational elements relevant to religion (Hackney & Sanders, 2003). Difficulties in defining and measuring religiosity are explored. Different forms of religiosity have been known to positively and negatively impact psychological well-being. The present paper identifies two types of religiosity (spirituality and orthodoxy). Spirituality positively impacts well-being, whereas orthodoxy contributes to negative well-being. The review concludes that both spirituality and orthodoxy are measured when religiosity is assessed.

Shame is understood as a painful self-conscious emotion (Tangney & Dearing, 2002). Self-compassion is contrasted to shame since it involves appraisal of the self and allows oneself to practise self-kindness and self-acceptance. Although existing research has yielded mixed results, the literature review supports the general prediction that orthodoxy should be related to greater shame and lower self-compassion, while spirituality should be related to lower shame and greater self-compassion.

1. Introduction

The role of religion in adverse life events, general psychological adjustment and well-being has always been of interest to psychologists. This paper raises the complexities concerned with defining and measuring religiosity. It then identifies how different forms of religiosity may impact mental well-being in a positive way (Maselko, Gilman & Buka, 2009; Smith, Hardman, Richards & Fischer, 2003a). It then moves on to discuss the relationship between religious belief and psychological problems (Maselko et al., 2009; Pargament et al., 1998). Evidence is critically appraised and gaps in knowledge such as limited research with non-Christian samples are identified.

The review then focuses on shame as a trans-diagnostic feature in mental illness. Shame is understood as a negative self-conscious emotion (Tangney & Dearing, 2002) and its similarities and differences with guilt are debated. The role of shame amongst South Asian (SA) women with psychological distress is discussed (Gilbert, Gilbert & Sanghera, 2004b). Shame is considered a negative emotion that contributes to and maintains distress (Gilbert, Clarke, Hempel, Miles & Irons, 2004a). Literature suggests that self-critical thinking leads on to experiences of shame (Gilbert et al., 2004a).

Associations between religiosity and shame proneness are discussed. Researchers have identified that religiosity may present greater risks of experiencing shame (Chau, Johnson, Bowers, Darvill & Danko, 1990; Luyten, Corveleyn & Fontaine, 1998; Woein, Ernst, Patock-Peckham & Nagoshi, 2003).

Shame is then contrasted with self-compassion that refers to self-kindness, non-judgement and self-acceptance (Neff, 2003a). This paper identifies that no research to date has examined the association between religiosity and self-compassion. Gaps in research are highlighted and the unknown relationship between religiosity, shame and self-compassion in SA Muslim women is identified.

2. Religiosity

The paper will now discuss how religiosity has been defined in the literature. To define religiosity, we draw on influential work by Allport and Ross (1967) about intrinsic and extrinsic religious motivations. The complexities of defining religiosity is then put into the context of research in order to consider how best to measure it.

2. 1. Defining and Measuring Religiosity

Researchers have studied one's strength of religiosity through religious behaviours (e.g. frequency of prayer and service attendance), religious salience (e.g. importance of religion) (Welch, Tittle & Grasmick, 2006), closeness to God, and religious or spiritual support (Hill, 2003).[1] Allport and Ross (1967) attempted to define religiosity by identifying individuals as either intrinsic or extrinsic. Individuals who are intrinsic "live" their religion. They may attend their religious institution (e.g. church) and pray to convey their religious beliefs rather than to gain rewards (Trimble, 1997). Extrinsic individuals tend to be involved in religion for external reasons. They "use" religion for social desirability purposes.

[1] The literature search strategy included empirical published journal articles that were retrieved from PsychLit and Web of Knowledge. Limits were set on these databases to access articles from 1970 to present. The search terms used were "religion", "religiosity", "spirituality", "religiousness", "orthodoxy" and "religious involvement".

In order to understand how accurate the intrinsic and extrinsic definitions are, we need to assess their credibility through assessment using scales or measures. The Religious Orientation Scale (ROS; Allport & Ross, 1967) was developed based on the intrinsic-extrinsic distinction. It was hoped that the ROS would help clarify the intrinsic-extrinsic distinctions. Not all participants fitted neatly into this definition. This initiated four subscales on the ROS according to intrinsic and extrinsic scores (pro-religious, intrinsic, extrinsic and anti-religious). Those that are pro-religious score highly on intrinsic and extrinsic items and are orthodox and dogmatically or fanatically devout.[2] The intrinsic subscale includes intrinsic items only reflecting a committed and devout nature. Extrinsic individuals are less orthodox, marginally committed to religion and score on extrinsic items only. Anti-religious individuals reject both intrinsic and extrinsic items. They are unorthodox and religiously uncommitted.

To eliminate confusion, this paper will use the term orthodoxy rather than pro-religious. The term orthodoxy is based on Allport and Ross's (1967) pro-religious distinction. Orthodox individuals are intrinsically and extrinsically religious and are highly committed to their religion. Orthodoxy includes beliefs, rituals and practices that pertain to a religious institution (Miller & Thoresen, 1999). Orthodox individuals may adhere to conventional religious practices that may include wearing traditional clothing that conforms to religious norms. An example of orthodoxy may be Jewish males wearing a traditional skullcap (Beit-Hallahmi, 1975). Spirituality, on the other hand, reflects a personal relationship with a deity or the universe that is intrinsic in nature (Piedmont & Leach, 2002). Spirituality involves creating meaning and

[2] Refer to Table One below

purpose for life that encompasses a sense of connectedness (Pargament, 1997).

Table 1: Subscales from the ROS

Subscale	Subscale items	Characteristics
Pro-religious	Score highly on intrinsic items Score highly on extrinsic items	Orthodox, dogmatic, fanatically devout
Intrinsic	Intrinsic items only	Devout, committed
Extrinsic	Extrinsic items only	Less orthodox, marginally committed to religion
Anti-religious	Reject intrinsic items Reject extrinsic items	Unorthodox, religiously uncommitted

In research, the term religiosity has included religious belief, practice, rituals and spirituality that has created some confusion. It is apparent that spirituality is a component of religiosity yet it requires its distinct identity. Piedmont, Ciarrochi, Dy-Liacco and Williams (2009) were the first researchers to investigate the problem of making a distinction between religiosity and spirituality in relation to psychosocial outcomes. Although Piedmont et al. (2009) used the phrase religiosity to refer to religiously motivated beliefs and behaviours, the term orthodoxy will be used here to eradicate confusion. The Spiritual Transcendence Scale (STS; Piedmont, 1999) was

used to measure spirituality. The STS consists of 24 items that fall into three subscales; Universality (life purpose belief), Prayer Fulfilment (praying or meditation creates feelings of joy), and Connectedness (feeling connected to others). Spirituality in the STS was defined as a personal meaning given to life. The Religious Involvement Scale (RIS; Piedmont et al., 2009) was used to measure orthodoxy. The RIS items seemed to map onto the orthodoxy definition that is why we categorised the measure as an assessment of orthodoxy. The RIS focuses on the behavioural aspects of religion (e.g. prayer frequency) where religion is defined with social traditions in mind. Spirituality and orthodoxy highly correlated (.71) but also demonstrated unique variance. Therefore, spirituality and orthodoxy are best regarded as related, yet distinct, constructs. These findings are true for an individualistic American sample. Piedmont et al. (2009) conducted a second study with a collectivist Filipino sample consisting on 86% Roman Catholic participants. Results confirmed orthodoxy and spirituality as correlated, yet distinct, constructs. These findings can be generalised across the lifespan (16-75 years) and individualistic and collectivist cultures. The evidence thus suggests that spirituality and orthodoxy correlate and at the same time are distinct constructs. These findings indicate that orthodoxy and spirituality need to be measured together to obtain a complete picture of religiosity.

There are variations in the measurement of religion in psychological research. Since spirituality is seen as a universal force (Piedmont et al., 2009) it is important to include it in the measurement of religiosity. Measures tend to be geared towards Christianity and limited thought has been given to multi-ethnic religious populations (Hill, 2003). Although many religions may share commonalities in terms of moral

transgressions, religions may vary in their teachings of beliefs and values. For instance, the Islamic faith is tied into collectivist culture and many of its teachings draw on family traditions, such as parental duties in finding a suitable husband or wife for one's son or daughter. Given that there may be variations in how religion is conceptualised from one faith to the next, it is important that we are able to draw from different religious affiliations in order to generalise empirical findings. King et al. (2005) developed the Beliefs and Values Scale (BVS). The BVS is not confined to a specific religion and focuses on overall spiritual belief that is not limited to religious thinking.

2.2. Summary

So far we can acknowledge the complex multi-faceted nature of religiosity. Defining and measuring religiosity is a difficult task given the correlation found between orthodoxy and spirituality (Piedmont et al., 2009). This association between orthodoxy and spirituality was established in individualist and collectivist cultures (Piedmont et al., 2009). However, spirituality and orthodoxy are also distinct constructs. There is evidence that spirituality and orthodoxy may form two components of religiosity. There are inconsistencies in how religiosity is measured. It appears that orthodoxy and spirituality need to be measured together in order to comprehensively understand the role of religiosity in well-being. This then may provide greater capacity to draw conclusions from the literature. Christian populations are over-represented in research that may limit our ability to generalise findings to other religious affiliations. Greater effort is needed to measure religiosity in other religions (King et al., 2005). The following section will explore the empirical research conducted on how different types of religiosity may have a

positive and negative impact on psychological well-being.

3. Positive and Negative Impact of Religiosity on Psychological Well-Being

Research has identified how religiosity can influence psychological well-being in a positive and negative way. This paper will now draw upon evidence to demonstrate how religiosity may act as a positive force in one's life as well as detrimental to their well-being.[3] Well-being is identified and understood in different ways and one may be characterised by the absence of mental illness (Sin & Lyobomsky, 2009). Well-being also relates to how psychological resources are used to achieve life satisfaction, happiness, positive emotions, meaning in life, healthy relationships and self-acceptance (Sin & Lyobomirsky, 2009). The review will firstly focus on the positive impact of religiosity on psychological well-being, then progress to evaluate the negative influence.

Although orthodoxy and spirituality have been identified as two forms of religiosity, very few studies included in this paper have actually made this distinction. Where the spirituality and orthodoxy distinction has not been made, the global term religiosity will be used. Measuring one aspect of religion (e.g. religious service attendance) is not a reflection of spirituality or orthodoxy as it is a purely behavioural component of religion. Therefore, we categorised such studies as measuring religiosity. This paper will categorise empirical research on psychological well-being into three groups; religiosity, spirituality and orthodoxy. For each section we will discuss studies assessing religiosity, spirituality then orthodoxy.

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[3] PsychLit and Web of Knowledge were consulted again to identify articles from 1970 to present. The search terms used were "religiosity AND well-being", "religiosity AND mental well-being", "religiosity AND mental health", "religiosity AND mental well-being", "religiosity AND distress", "religiosity AND psychological well-being".

3.1. Positive Psychological Well-Being

The following sections will explore how religion may be useful in maintaining healthy well-being. The valuable role religion plays in helping one cope with negative life events will also be debated.

3.2. Well-Being[4]

This section will discuss how religiosity has positively affected life satisfaction, happiness and general psychological adjustment. Leondari and Gialamas (2009) explored psychological well-being and religiosity using a Greek Orthodox sample. Church attendance was the only variable that associated with better life satisfaction. This confirms that one aspect of religiosity (i.e. church attendance) has a positive impact on well-being. It was not possible to make the orthodoxy and spirituality distinction given the behavioural method of church attendance as a measure of one's religious commitment. Therefore, this study fell into the religiosity category. Social contact may be gained through church attendance (Hall, Meador & Koenig, 2008). From these results it is unclear if religiosity enhances well-being, or if this relationship is complicated by social support. Interestingly, no other measures of religiosity were associated with well-being. Religiosity was not associated with depression or loneliness. Therefore, their hypothesis that more religious individuals would be less psychologically distressed was not confirmed.

Milevsky and Levitt (2004) established a positive association between religiosity and better psychological adjustment in pre-adolescents and adolescents. The sample was

[4] Refer to Table Two on page 26 to view a summary of the religiosity and positive well-being studies used in this review. The table clearly states what category each study falls under i.e. religiosity, spirituality or orthodoxy.

ethnically diverse with African-American, European-American and Hispanic-American participants. We categorised this study as religiosity and orthodoxy. Religiosity was measured using the intrinsic-extrinsic distinction. To measure extrinsic religiosity, participants were asked, “How often do you take part in religious activities, such as attending services, Sunday school, or youth group activities?” Intrinsic religiosity was measured by asking “How important is religion to you?” Using these two items of religiosity, participants were categorised into “intrinsic”, “extrinsic”, “religious” and “non-religious”. The “religious” group (those who scored high on intrinsic and extrinsic items) will be referred to as orthodox since it is the same as Allport and Ross’s (1967) “pro-religious” group. The “orthodox” and “intrinsic” group showed greater psychological adjustment than the “non-religious” group. This may suggest that religion is a driving force in maintaining positive mental health as early as pre-adolescence. Although this indicates that both orthodoxy and intrinsic religiosity have a positive impact on well-being, we must approach these results with caution. Two single items are not sufficient to accurately reflect such a multi-faceted concept as religiosity (Pargament, 2002).

Suhail and Chaudhry (2004) carried out a study on the Muslim population in Pakistan. They used the Religiosity Scale which was specifically developed by the authors to be used with Muslims. This measure focused on beliefs and practices pertaining to Islam and the items were generated with Islamic religious books in mind (Holy Quran and Hadith). The items were about Islamic belief in one God (Allah), beliefs about life after death and the prophet Mohammed. Items also measured religious practice that asked about prayer, reading the Holy Quran, pilgrimage, charity and living a life according to Islamic rules. This seemed to reflect

what is categorised as orthodoxy. We acknowledged their research as an orthodox study. A positive association between orthodoxy and well-being (i.e. personal happiness and life satisfaction) was established. Their hypothesis that orthodoxy would be the strongest predictor for well-being was not supported. Work satisfaction and social support were better predictors of well-being.

3.3. Mental Health

Attention will be drawn to evaluate how religiosity may impact mental health in a positive way. Maselko et al. (2009) established that those attending religious services are 30% less likely to experience a Major Depressive Episode (MDE) in contrast to those who never attended services. Their findings are consistent with others (Strawbridge, Shema, Cohen & Kaplan, 2001). Their study fell into two categories as they initially investigated religiosity then spirituality. Religiosity was measured using a purely behavioural method by asking participants if they attend a place of worship. Through attending religious services, one maintains social networking which is important in maintaining psychological well-being (Hall et al., 2008). Therefore, it is unclear if social networking may be a confounding variable in explaining the reduced MDE amongst religious service attendees. Nonetheless, religious involvement offers opportunities for social support, which may play a role in protecting individuals against depression.

These results are consistent with the stress-buffering model (Cohen & Wills, 1985). In this model religiosity acts as a buffer in stressful life events, suggesting that there should be a stronger relationship between religiosity and depression when stress levels are high. A meta-analysis by Smith, McCullough and Poll (2003b) revealed a

negative relationship between religiosity and depression that was most powerful during the experience of a stressful life event. Hence, religiosity may act as a protective force as when stress levels were high depression was low. This also supports the buffering hypothesis. The main-effect model (Smith et al., 2003b), on the other hand, expects the relationship between religiosity and well-being to be evident at all levels of stress. Smith et al. (2003b) also found evidence for the main-effect model. Religiosity and depression scores negatively correlated at all levels of stress. Thus, although Smith et al. (2003b) found that religiosity negatively correlated with depression at all levels of stress, the correlation was most strongly negative when stress was high.

Maselko et al. (2009) used an adapted form of the Spiritual Well-Being Scale (SWBS; Ellison, 1983) to measure spirituality. With greater existential well-being there is a reduced chance of MDE by >70%. Existential well-being taps into one's life purpose, meaning and satisfaction. It appears that reporting greater positive emotions about these areas may act as a buffer against depression.

Maselko et al.'s finding is supported by Smith et al.'s (2003a) eating disorders study. Spiritual well-being positively correlated with eating disorders outcome. Those that expressed greater spirituality tended to have healthy eating attitudes, were less concerned about body shape, and functioned better psychologically and socially.

Pargament et al. (1998) established religiosity to have a positive impact on patients going through a mental health crisis. They used a life event-related Religious Outcome measure that assessed "perceived changes in closeness to God, closeness to

the church, and spiritual growth in response to the event" (Pargament, 1990, p. 806). They also administered the Red Flag measure that was specifically developed for this study to identify religious warning signs in a mental health crisis. The items assess belief in God, closeness to God, commitment to religion, religious rituals and practice and interpersonal conflicts involving family, friends and the church. We identified this as a measure of orthodoxy since its items were consistent with the orthodoxy definition. Hence, Pargament et al.'s study was categorised as orthodoxy. Those who heavily used orthodoxy and neglected other needs tended to have better mental health and cope better with a life event. Patients who used orthodoxy to justify life events in a positive way also presented with better mental health and coped well with life events. It appears that orthodoxy can be used as a resource at difficult times. These findings are also consistent with the stress-buffering model (Cohen & Wills, 1985) since orthodoxy played a positive role in dealing with a negative life event. Pargament et al.'s (1998) findings demonstrated that those who placed greater importance on personal goals and neglected orthodox values experienced poorer mental health when coping with the loss of a significant other. It appears that orthodoxy may be beneficial in maintaining positive mental well-being at crisis point.

3.4. Religious Coping

Research has been conducted on religious coping in mental health difficulties. Positive religious coping involves the use of religious beliefs and practices to empower one to problem-solve or manage emotional pain caused by a stressful life event (Koenig, Pargament & Nielsen, 1998). Pieper (2004) used a sample of Dutch in-patients to identify how religious coping and religiosity related to psychological

well-being. This study fell into two categories as religiosity and spirituality were both investigated. Intrinsic religiosity was measured using three items from the Duke Religion Index (Koenig, Parkerson & Meador, 1997). The Spiritual Well-being Scale (Paloutzian & Ellison, 1991) was used to measure spirituality, and psychological well-being was assessed using anxiety scales.

Pieper's regression analysis revealed a significant correlation with psychological well-being and four indicators of religiosity. These four indicators of religiosity were (i) being intrinsically religious, (ii) maintaining a positive relationship with God, (iii) using positive religious coping and (iv) collaboratively coping (i.e. the individual works collaboratively with God to problem-solve). It appears that having religious beliefs, engaging in religious activities and using religion to overcome difficult life events may be beneficial in reducing one's level of anxiety. Positive religious coping was the only independent predictor for psychological well-being. Generally, spirituality was beneficial in facilitating coping with an adverse life event.

A meta-analysis by Ano and Vasconcelles (2005) found a moderate positive correlation between positive religious coping and positive psychological adjustment. Across 29 studies an effect size of .33 (95% CI= .30-.35) was established. Those that use religion in a positive way (e.g. gaining perspective) may present as more psychologically healthy. They found no significant association between negative religious coping and positive psychological adjustment (effect size= .02, 95% CI= -.02- .05). It seems that there is no evidence to suggest that using religion in a negative way to cope with life events is beneficial or harmful to mental well-being.

3.5. Summary: Positive Well-Being

The way religiosity has been measured by researchers may indicate its beneficial qualities in managing emotional distress and acting as a buffer against stress (Smith et al., 2003b). However, there is a lack of clarity in these findings about the beneficial role of religiosity. This is largely down to variations in defining and measuring religiosity. Some have measured a single component of religiosity such as service attendance positively impacting life satisfaction (Leondari & Gialamas, 2009). Yet the social contact gained from service attendance may explain the positive relationship between religiosity and well-being. Given the multi-faceted nature of religiosity, we are unclear if religiosity is being measured adequately. Evidence suggests there may be two components to religiosity (spirituality and orthodoxy) that affect well-being in different ways. Maselko et al. (2009) and Smith et al., (2003a) found spirituality positively impacting well-being. Orthodoxy was found to be useful in helping one cope with a negative life event (Pargament et al., 1998). Suhail and Chaudhry (2004) found work satisfaction and social support to be better predictors of well-being than orthodoxy. The evidence of spirituality having a positive impact on well-being is strong. Whereas the positive impact of orthodoxy on mental health is less clear as few studies have made the orthodoxy distinction when they have measured religiosity. The evidence suggests that orthodoxy is useful under some circumstances, for example when a negative life event is experienced (Pargament et al., 1998). Furthermore, Christian samples have been used predominantly with the exception of Suhail and Chaudhry's (2004) Muslim participants. The use of other religious affiliations may help us clarify some of the evidence as well as provide scope for generalising findings. The dearth of research using other religions highlights the need for further research.

Table 2: Studies demonstrating religiosity positively impacting well-being

Study	Study category	N	Age	Religion	Religiosity measure	Main findings	Limitations
Leondari & Gialamas (2009)	Religiosity	363	18-48 yrs Mean age = 24.6 yrs	Greek Orthodox	Frequency of prayer, church attendance and interest in religion. Single item belief about God	Greater church attendance relates to better life satisfaction. No association between religiosity and depression or loneliness.	Religiosity measures not validated. Church attendance includes social contact.
Maselko et al. (2009)	Spirituality Religiosity	918	Mean age= 39 yrs	Christian	SWBS Religious service attendance	Religious service attenders are 30% less likely to experience MDE Greater existential well-being then less chance of MDE Religious well-being negatively affects well-being	Cross-sectional design so associations cannot be confirmed There may be variations in interpreting SWBS items

Study	Study category	N	Age	Religion	Religiosity measure	Main findings	Limitations
Milevsky & Levitt (2004)	Religiosity, intrinsic religiosity and orthodoxy	694	11-15 yrs Mean age =12.69 yrs	Not reported	Intrinsic and extrinsic measure	African-Americans were more intrinsic. Religiosity and orthodoxy related to better psychological adjustment. No significant difference between intrinsic and extrinsic religiosity.	Religiosity measures not validated. Cannot generalise to other age groups or religions.
Pargament et al. (1998)	Orthodoxy	49 church sample 196 college sample	22-81 yrs Mean age = 50 yrs 18-54 yrs Mean age = 20 yrs	Catholic and Protestant	Religious Outcome Religious Red Flags	Religiosity has a positive impact when a mental health crisis is apparent Religion used to justify negative life event helps one deal with difficulties.	No control group Long-term implications unknown.

Study	Study category	N	Age	Religion	Religiosity measure	Main findings	Limitations
Pieper (2004)	Religiosity and intrinsic religiosity Spirituality	116 Dutch in-patients	18-79 yrs Mean age = 39 yrs.	Reformed Protestant	Duke Religious Index SWBS	Existential well-being associated with positive religious coping. Psychological well-being associated with positive religious coping.	Highly religious sample. Self-report well-being measures.
Smith et al. (2003a)	Religiosity and intrinsic religiosity Spirituality	251 females	12-56 yrs Mean age =21.85yrs	Christian	Religiosity subscale from ROS Religious affiliation Spirituality subscale from SWBS	Positive correlation between spirituality and eating disorders outcome. Intrinsic religiosity and religious affiliation does not reduce mental health	May be specific to in-patient sample. No control group.

Study	Study category	N	Age	Religion	Religiosity measure	Main findings	Limitations
Suhail & Chaudhry (2004)	Orthodoxy	973	16-80 yrs Mean age = not reported	Muslim	Religiosity Scale	Positive association between orthodoxy and well-being. Orthodoxy not strongest predictor for well-being	Well-being was assessed using self-report measures. No control group.

3.6. Negative Psychological Well-Being

The paper will now assess how religiosity may play a role in negatively impacting one's sense of well-being. An increase in mental illness and an inability to cope with adverse life events may involve having a maladaptive relationship with religion.

3.7. Mental Health

Pieper (2004) established in his in-patient study that those who actively practised religious rituals (e.g. praying or Bible reading) tended to experience greater anxiety.[5] Religious practices and maintaining a positive relationship with God can be viewed as part of an obsessive ritual. Leondari and Gialamas (2009)[6] support Pieper's (2004) results since they established a significant association between frequency of prayer and anxiety in a sample of undergraduate students. These findings are consistent with the stressor response model (Ellison & Levin, 1998). This model suggests that a particular stressor (e.g. bereavement) encourages one to increase the frequency of their religious behaviours. Therefore, those with greater anxiety may use prayer as a method of dealing with stress.

Studies have predominantly used Christian participants which makes it difficult to generalise findings. It is important to draw our attention to studies that have used other religions. A study by Inman (2006) used SA women from various religions. Inman's study was included in the religiosity category since their measurement of religiosity was not adequate to be identified as spirituality or orthodoxy. They found that those who identified themselves as "very religious" reported greater levels conflict within their intimate relationships. Level of religiosity tended to be more

[5] Pieper's (2004) research was identified as a religiosity and spirituality study.
[6] Leondari and Gialamas's (2009) research was regarded as a religiosity study.

predictive of conflict within intimate relationships in second generation than first generation SA women. This suggests that there may be generational differences in how religion is used. Participants were Christian, Hindu, Sikh, Muslim Buddhists and other. It is difficult to say if these findings are representative given the range of religious affiliations and the limited number of participants in each religious group. Another limitation is that religiosity was not assessed using a standardised tool. Participants identified themselves as "very, somewhat or not at all religious." From these findings we are not clear if women are more religious because their religious practice allows them to cope with their relationship conflicts, or if their religion plays a role in conflicts within their intimate relationships. Inman's findings remain valuable in indicating that those who are more religious may report greater conflict within their intimate relationships.

Smith et al. (2003a) investigated eating disorders treatment outcome. They used the intrinsic religiosity subscale from the ROS (Allport & Ross, 1967) and religious affiliation. Therefore, their study was classified as measuring religiosity. Intrinsic religiosity and religious affiliation were not significantly associated with declining eating disorder symptoms. These findings suggest that religiosity may not be beneficial for eating disorders outcomes, that is in contrast to spirituality. As mentioned earlier, their study established spirituality to have a positive impact on women with eating disorders at post-treatment.

3.8. Coping

This section will discuss how forms of religiosity may be a hindrance to those coping with negative life events. Pargament et al. (1998) aimed to identify warning signs for

problematic religious coping. Their sample included church attendees and college psychology students who had experienced a negative life event in the past two years. Church attendees formed the "church group". Students were divided into two groups. One group included college students that experienced the death of a significant other (CSD). The other group included those that encountered personal injustice (CSU). The sample consisted of three groups in total (church, CSD and CSU). They used validated measures of self-esteem, anxiety and problem-solving to assess mental well-being. The Religious Outcome (Pargament et al., 1990) and Red Flag measure were used to identify religious warning signs at crisis point. We stated earlier in this paper that the Red Flag was identified as a measure of orthodoxy, therefore we identified this as a study about orthodoxy. The measure consisted of three subscales that conceptualised one's relationship with their religion. These three subscales were (i) "wrong direction", (ii) "wrong road" and (iii) "against the wind."

Results showed that those with greater "religious apathy" (a component of the wrong direction subscale) demonstrated significantly lower self-esteem, limited problem-solving and poorer life event outcome. One may experience negative well-being as a result of giving religion greater importance at the cost of undervaluing oneself and others (religious apathy).

"Punishing God" (wrong road subscale) was associated with lower self-esteem and increased anxiety for the church sample. Those who believe that God is punishing them with a negative life event are more anxious and have reduced self-esteem. Those who felt God was punishing them with negative life events also expressed negative mood across both college and church samples. This may suggest that the

appraisal of a negative life event involves one believing that God is punishing that is accompanied with anxiety, poor self-esteem and low mood. We do not know if anxiety, poor self-esteem and low mood were present prior to the negative life event experience.

"Religious passivity" (wrong road subscale) was significantly associated with negative event outcome for the CSD sample. Those who give full responsibility to God to manage their problems experience greater distress in coping with bereavement. However, religious passivity was significantly associated with positive religious outcomes across all samples. Therefore, religious passivity is associated with opportunities for spiritual growth, closeness to God and the church.

"Religious vengeance" (wrong road subscale) was significantly correlated with negative mood for the church and CSD samples. Those that used religion to hurt or punish others expressed greater mood difficulties. This suggests that religion may play a role in facilitating aggression towards others, yet we are unclear if a drive to harm others and mood difficulties were present in individuals prior to their strong religious values.

Those who were "angry with God" (against the wind subscale) because of experiencing negative life events had worse mental health and events outcomes. If one feels anger towards God then this may be detrimental to their mental well-being. Negative events and religious outcomes were significantly associated with "religious doubts" (against the wind direction) for the CSD group. In all three samples, a significant association between religious doubts and poorer problem solving-skills

and negative mood were found. This suggests that those who experience religious doubts may feel unable to problem-solve and suffer from low mood. We are not clear if low mood and poor problem-solving abilities were apparent prior to having religious doubts. Or that religious doubts may be a feature of one experiencing low mood, for instance if one questions experiencing the negative life event.

Church members who experienced “interpersonal religious conflict” (against the wind subscale) were more anxious. Conflicting with friends, family and congregation members over religion may increase levels of anxiety. Religious conflict was significantly associated with negative mood for the CSU group. Religious conflict was significantly associated with poorer problem-solving skills, negative religious outcomes and negative mood for the CSD sample. Engaging in religious conflict may be associated with poor well-being as well as one's relationship with their faith.

CSD participants who “conflicted with church dogma” (against the wind subscale) struggled with problem-solving skills, presented with increased negative religious outcome and negative mood. Church members who conflicted with church dogma presented with lower self-esteem and negative religious outcome. This may suggest that conflicting with church dogma may be problematic for well-being.

Overall, Pargament et al.’s (1998) findings indicate that “religious apathy”, “God’s punishment”, “anger at God”, “religious doubts”, “interpersonal religious conflicts” and “conflict with church dogma” subscales may associate with mental health and event related outcomes in a negative manner. This study demonstrates how orthodoxy may be associated with poor mental well-being and limited coping skills

to deal with adverse life events.

It is important to draw upon the process-integration model (Pargament, 1992) to understand these findings. This model assesses to what extent one integrates their beliefs, values, emotions and behaviours to cope with adverse life events. Coping is unique in each situation. Therefore, coping will vary across situations and contexts. The process-integration model is relevant to clinical practice since psychologists are curious about how one copes and responds to different stressors. Pargament et al.'s (1998) findings are consistent with the process-integration model since religious coping is not always helpful nor is it always harmful. It seems that acknowledging and understanding one's relationship with religion is important when assessing psychological state.

A meta-analysis by Ano and Vasconcelles (2005) established a positive correlation between negative religious coping and negative psychological adjustment. Using 22 studies an effect size of .22 (95% CI= .19- .24) was detected. This indicates that if religion is used in a negative light (e.g. punishment from God reappraisal) then psychological distress may be experienced. Together these findings may indicate that religious coping is a complex phenomenon. Individuals may use positive or negative religious coping to overcome an adverse life event that may be either beneficial or harmful to their mental well-being.

Table 3: Studies demonstrating negative impact of religiosity on well-being

Study	Study category	N	Age	Religion	Religiosity measure	Main findings	Limitations
Inman (2006)	Religiosity	193 South Asian females 63 first generation 130 second generation	20-60 yrs Mean age = 30.90 yrs 18-37 yrs Mean age = 26.88 yrs	Christian, Hindu, Sikh, Muslim Buddhists and other	Participants asked how religious they are	"Very religious" participants reported greater intimate relations conflict Second generations had greater religiosity and intimate relations conflict.	No validated religiosity measure used. There may be differences between religions and within South Asian cultures.
Leondari & Gialamas (2009)	Religiosity	363	18-48 yrs Mean age = 24.6 yrs	Greek Orthodox	Frequency of church attendance Single item belief about God	Association between frequency of prayer and anxiety	Religiosity measure not validated.

Study	Study category	N	Age	Religion	Religiosity measure	Main findings	Limitations
Maselko et al. (2009)	Spirituality Religiosity	918	Mean age = 39 yrs	Christian	SWBS Religious service attendance	For higher religious well-being the odds were greater for MDE	Cross-sectional design so associations cannot be confirmed.
Pargament et al. (1998)	Orthodoxy	49 church sample 196 college sample (CSD, N= 98; CSU, N= 98)	22-81 yrs Mean age= 50 yrs 18-54 yrs Mean age= 20 yrs	Catholic and Protestant	Religious Outcome Religious Red Flags	Various religious dimensions in Red Flag measure have negative impact on mental health and event related outcomes.	No control group. No validated measure of religious affiliation.
Pieper (2004)	Religiosity and intrinsic religiosity Spirituality	116 Dutch in-patients	18-79 yrs Mean age= 39 yrs.	Reformed Protestant	Duke Religious Index SWBS	Association between religious practice and anxiety.	Highly religious sample so cannot generalise findings.

Study	Study category	N	Age	Religion	Religiosity measure	Main findings	Limitations
Smith, Hardman, Richards & Fischer (2003)	Religiosity and intrinsic religiosity Spirituality	251 females	12-56 yrs Mean age = 21.85 yrs	Christian	Religiosity subscale from ROS Religious affiliation	Intrinsic religiosity and religious affiliation does not reduce mental health	May be specific to in-patient sample. No control group.

3.9. Summary: Negative Well-Being

Studies concerning religiosity and positive well-being are more common than negative well-being studies. Some religious behaviours (e.g. praying) can act as a coping mechanism for stress and these people present with symptoms of anxiety (Pieper, 2004). It is difficult to generalise these findings since research has used mainly Christian samples. One of the exceptions is the study by Inman (2006) that found greater religiosity amongst second generation SA women to be associated with higher rates of conflict within intimate relationships. With this association, we are unclear on if these women were more religious because of having to cope with relationship conflict. Further research with SA women needs to identify the role of religiosity in well-being using specific religious groups. Intrinsic religiosity and religious affiliation was unrelated to or negatively influenced eating disorders outcomes, yet spirituality was beneficial at post-treatment (Smith et al., 2003a). Pargament et al. (1998) found how religious coping may be associated with poor well-being. Pargament et al.'s (1998) findings provide evidence for the argument that orthodoxy may relate to difficulties with mental well-being. Overall, there is more evidence to suggest that spirituality positively impacts well-being, since it has been studied more frequently. Unfortunately orthodoxy has not been studied as much which is why there is limited evidence to suggest its negative impact on well-being. Nonetheless, Pargament et al.'s (1998) findings indicate the need for further research into orthodoxy and negative well-being.

So far we can acknowledge that religiosity can sometimes have a positive impact on well-being but that it has also been found to have a negative impact on well-being. We proposed two components of religiosity, that is spirituality might be associated

with positive outcomes, and religious orthodoxy might be related to more negative outcomes. If we break down negative well-being we can understand that critical thinking and self-judgement are significant features of emotional distress. A negative emotional construct such as shame can be maladaptive in nature and maintain psychological problems (Gilbert, 2000). We were particularly interested in assessing well-being using shame and self-compassion. We were curious about how shame and self-compassion map onto spirituality and orthodoxy. We anticipate that spirituality may relate to self-compassion given its kind and forgiving nature and orthodoxy may foster shame as it is conceptualised as punitive. Previous research has not clarified the relationship between orthodoxy and spirituality, possibly because religiosity measures have not made this distinction. In addition, global well-being measures may be too broad (e.g. depression), thus unable to detect associations with spirituality and orthodoxy. Shame is a specific trans-diagnostic feature which may be more successful in relating to orthodoxy.

4. Shame:

Defining Shame: Similarities and Differences between Shame and Guilt

Shame and guilt are both self-conscious emotions that are experienced by most individuals (Woien et al., 2003).[7] Both emotions occur when one fails to meet standards they have set themselves. It can be experienced as a result of failure or transgressions (Tangney & Dearing, 2002). The concept of shame and guilt is presented in the following section. Literature suggesting similarities and differences between shame and guilt are critically appraised.

[7] Web of Knowledge and PsychLit yielded empirical journal articles after the following search terms were used; “shame”; “shame AND religion”; “shame AND mental health”; “shame AND spirituality”; “shame AND South Asians”; “shame AND Islam”, “shame AND Muslims”.

4.1. Similarities between Shame and Guilt

There is a great deal of confusion around shame and guilt. They are both negatively valenced, moral, self-conscious and self-referential emotions (Tangney & Dearing, 2002). When one experiences shame or guilt there is a desire to undo actions (Friyda, Kuipers & ter Schure, 1989). They both involve feelings of distress and are experienced following the performance of a moral transgression. Research indicates (Tangney, Wagner, Hill-Barlow, Marschall & Gramzow, 1996) that shame and guilt proneness correlate between .40-.50 in the Test of Self-Conscious Affect (TOSCA; Tangney, Wagner & Gramzow, 1989). Thus, although the emotions share commonalities, they are best regarded as related, yet distinct.

4.2. Differences between Shame and Guilt

Keltner and Buswell (1997) made distinctions between shame and guilt. They believe shame is concerned with not living up to personal standards, whereas guilt is evoked by committing actions that caused harm to others or the breach of personal duties. The experience of shame is considered to be highly distressing, where one blushes, feels self-conscious and small (Roseman, West & Schwartz, 1994). With guilt, one realises they have done something wrong and wishes to undo their actions. Guilt is characterised by seeking forgiveness from the hurt party and an inclination to repair the situation.

Guilt has been identified as adaptive, whereas shame has been considered as unhealthy and maladaptive (Tangney & Dearing, 2002). Research offers support to this claim as psychologically adaptive constructs are associated with dispositional guilt proneness. Psychologically maladaptive constructs have been found to be

associated with dispositional shame proneness. For example, shame proneness has been related to personal distress (Leith & Baumeister, 1998), neuroticism (Johnson, Danko, Huang Park, Johnson & Wagoshi, 1987) and low self-esteem (Tangney, Burggraf & Wagner, 1995). Leith and Baumeister (1998) and Tangney (1991) have identified guilt proneness to be associated with empathic concern, perspective-taking and subscription to conventional morality.

Shame and guilt are associated with different cognitions, motivations, behaviours, evaluations and feelings. Shame tends to pertain to negative self-evaluations (e.g. "I'm a bad person) and avoidance behaviours (e.g. leaving a situation or hiding). Guilt is concerned with negative behaviour evaluations (e.g. feeling bad about a performed behaviour) and approach behaviours (e.g. attempting to rectify one's transgression). A shameful experience can be extremely painful and devastating (Tangney, 1992). One focuses beyond a specific behaviour and scrutinises the entire self. Hence, one concentrates on the "bad self" rather than the "bad thing".

4.3. Shame and Mental Health

Shame can be "internalised" and have the ability to emotionally cripple one since it involves analysis of the core identity (Goss, Gilbert, & Allan, 1994). The intensity of these negative feelings can lead to one appraising the self as bad, dirty, worthless or hopeless (Claesson & Sohlberg, 2002). "Externalised" shame refers to how one is perceived by others (Gilbert, 1997) and experiences of stigma (Pinel, 1999). There is a tendency to hide away as one is concerned about others finding out. This relates to how one is perceived by others as rejection is a feared consequence. Depression has been associated with "internal" (Tangney et al., 1995) and "external" shame (Gilbert,

Allan & Goss, 1996).

Shame has been established as a key negative emotion in mental health difficulties such as depression (Gilbert, 2000; Gilbert et al., 1996; Tangney et al., 1995), anxiety (Gilbert, 2000) and Post-Traumatic Stress Disorder (PTSD; Lee, Scragg & Turner, 2001). The role of shame amongst SA women with mental illness has been of great interest to psychologists (Gilbert et al., 2004b). Mesquita (2001)[8] argues that there is a distinction in how emotions are conceptualised in individualist and collectivist cultures. In individualist cultures emotions are related to reflections on the self. Whereas in collectivist cultures, emotions are associated with how one's behaviour reflects on others. Gilbert (2002) attempted to link the collectivist and individualist emotional distinction to shame. Within SA cultures, one can experience personal shame as a result of their own behaviours but also bring shame onto others (Gilbert, 2002, Gilbert et al., 2004b). Together these findings demonstrate that shame amongst SA Muslim women is particularly important given the addition of cultural dynamics, thus greater research is needed to gain a more comprehensive understanding.

4.4. Shame and Religiosity

The following section will debate how religiosity and shame may be associated. Empirical research included in this section did not make the spirituality and orthodoxy distinction. Therefore they will be referred to as studies investigating religiosity and shame. Woien et al. (2003) examined the relationship between shame and religiosity using the Test of Self-Conscious Affect (TOSCA; Tangney, Wagner & Gramzow, 1992). The TOSCA consists of shame and guilt subscales. The scale

[8] It is beyond the scope of this paper to review the literature on shame and culture.

assesses one's emotional reactions in imagined hypothetical situations. The intrinsic and extrinsic scale from the revised ROS (Gorsuch & McPherson, 1989) and SWBS were used to measure religiosity. A small correlation between shame and extrinsic religiosity was established. Although the association was small, it suggests that those who use their religion for social desirability purposes are likely to experience greater shame. Chau et al., (1990) also found a positive correlation between shame and extrinsic religiosity.

Luyten et al. (1998) studied the relationship between shame and religiosity. To assess shame, they used the TOSCA and asked participants how frequently they experienced shame. Religious involvement was assessed using questions such as "How religious do you consider yourself?" Religious belief was assessed by asking participants if they are believers or non-believers. Other questions were asked to assess religious attitudes. Luyten et al. (1998) found a positive correlation between religious involvement and shame frequency and TOSCA shame scores.

4.5. Summary: Shame and Religiosity

Shame is distinct to guilt as it involves evaluation of the entire self. It contains a high self-blame and self-critical component where one internalises negative feelings that may lead to mental health problems (Gilbert, 2000; Lee et al., 2001). Attention has been drawn to significant shame experiences amongst SA women (Gilbert et al., 2004a), that is an area in need for further research. Shame proneness has been associated with religiosity (Chau et al., 1990; Woein et al., 2003). Luyten et al. (1998) further identified an association between religious involvement and shame frequency and TOSCA shame scores. There is a serious dearth of research in this

field. Future studies need to examine the spirituality and orthodoxy components of religiosity and their distinction in relation to shame.

Since shame and self-compassion are indicators of psychological well-being, we were intrigued to learn how they relate to both forms of religiosity (orthodoxy and spirituality).

5. Self-Compassion

The term "compassion" usually refers to being compassionate or kind towards others. "Self-compassion" refers to the ability to acknowledge one's own suffering. The term is derived from Buddhist psychology where it is strongly believed and practised that one must be compassionate towards themselves and others. Through being self-compassionate, one must be non-judgemental and accept their failings and flaws are what make them human. To be self-compassionate, one is ultimately kind to themselves (Neff, 2003a). One must engage in meta-cognitive activity to gain perspective on their experiences. They are encouraged to refrain from over-identification with their experiences as they risk becoming too absorbed in their painful emotions (Neff, 2003a). Therefore, the self-compassionate attitude is neatly embedded in "mindfulness" (Kabat-Zinn, 1994). Mindfulness is understood as a way of being. To be in a mindful state, one must be non-judgemental, notice and acknowledge their thoughts and emotions and not refrain from them. One needs to be in a mindful state to be self-compassionate. Self-compassion involves three elements (Neff, 2003a). Firstly, one needs to refrain from self-criticism and judgement and be kind to oneself. Secondly, one must acknowledge that their experiences make them human. Thirdly, one needs to hold their painful thoughts and emotions and not over-

identify with them.

Self-compassion encourages non-judgement and self-acceptance (Neff, 2003a), whereas shame involves self-blame, self-criticism and internalisation of negative feelings (Gilbert, et al., 2004a). Therefore, shame and self-compassion are opposite to one another and are both indicators of psychological well-being, with shame being indicative of negative well-being and self-compassion being indicative of positive well-being.

Gilbert et al. (2004a) identified the "inner critical dialogue" that is apparent in the relationship one has with oneself.[9] When the inner critical dialogue is continuously activated it leads to feelings of shame. Research suggests that self-criticism plays a significant role in depression (Gilbert, Baldwin, Irons, Baccus & Palmer, 2006; Zuroff, Moskowitz & Cote, 1999). Self-criticism is initiated when one experiences failure or feels undervalued. Consequently, feelings of shame are activated (Gilbert et al., 2004a). Gilbert et al. (2006) established that depression positively associated with negative thinking. A negative correlation was found between depression and self-reassurance. Therefore, depression is characterised by negative thinking, high self-criticism and low self-reassurance. Depressed individuals struggle with self-compassion and self-reassurance yet have greater capacity to self-criticise (Gilbert et al., 2006).

[9] Self-compassion is a recent phenomenon to the field of Psychology so there is a lack of research conducted to date. Under these circumstances the literature search had to draw upon material concerned with self-criticism and its relationship with shame and self-compassion.

5.1. Self-Compassion and Mental Health

Self-compassion has been considered as a strategy that maintains emotional regulation (Leary, Tate, Adams, Allen & Hancock, 2007). Having a compassionate mind can enable one to be kind to themselves that has benefits for maintaining healthy psychological well-being (Gilbert, 2009).[10] Positive correlations have been established between self-compassion and psychological well-being (Neff, Hsieh and Dejitterat, 2005) and adaptive psychological functioning (Neff, Kirkpatrick & Rude, 2007). Self-compassion accounts for unique variance in depression and anxiety despite trait self-esteem being partialed out (Neff, 2003b). This suggests that self-compassion and self-esteem are distinct constructs.

5.2. Self-Compassion and Religiosity

Self-compassion is derived from Buddhist psychology that has a high spiritual component. Using the self-compassion scale, Neff (2003b) compared a sample of Buddhist practitioners to undergraduates. Buddhist practitioners practised a form of meditation that drew on mindfulness, including awareness of all beings, compassion towards others and the self. Buddhists presented with higher self-compassion than undergraduates. This finding encourages further research since we do not know how superior levels of self-compassion in Buddhists may relate to their mental well-being. No measure of religiosity was included therefore we do not know the religious affiliations of the undergraduates. Future research needs to explore self-compassion in relation to specific religious affiliations. In Neff's (2003b) other studies,

[10] PsychLit and Web of Knowledge databases were consulted to identify empirical journal articles using the following search terms; "self-compassion", "self-kindness", "self-compassion AND mental health", "self-compassion AND psychological distress"; "self-compassion AND well-being", "self-compassion AND spirituality", "self-compassion AND religion"; "self-compassion AND religiosity"; "self-criticism AND self-compassion"; "self-compassion AND shame".

undergraduate women were less self-compassionate than men. In her Buddhist sample, however, there was no gender difference in self-compassion. This finding may suggest that mindfulness based meditation and Buddhist practice may particularly benefit female mental well-being.

We could not identify any research to date that explored the relationship between religiosity and self-compassion. Since this relationship has never been researched it is crucial that attempts are made to identify the relationship between religiosity and self-compassion. So far this paper has identified that two forms of religiosity (orthodoxy and spirituality) may contribute to well-being. Spirituality has been established to play a positive role in mental well-being (Maselko et al., 2009), whereas orthodoxy has been associated with psychological difficulties (Pargament et al., 1998). Future research needs to identify how these components of spirituality relate to self-compassion.

5.3. Summary: Self-Compassion and Religiosity

Self-compassion may act as a buffer against depression and help one maintain a healthy well-being. To date there is no research that has specifically examined the relationship between religiosity and self-compassion. Future research needs to consider spirituality and orthodoxy when exploring the association between religiosity and self-compassion.

6. Religiosity, Shame and Self-Compassion in South Asian Muslim Women: Clinical Generalizability

This paper proposes that religiosity may encompass spirituality and orthodoxy, that

affect psychological well-being in different ways. Spirituality has been associated with healthy well-being and positive outcomes (Maselko et al., 2009; Smith et al., 2003a). Orthodoxy has been found to negatively impact well-being (Pargament et al., 1998). This is an important finding since it demonstrates that religiosity as a construct is multi-faceted and its application may either be positive or negative to well-being. It is crucial to understand this relationship between religiosity and well-being by breaking down the well-being and religiosity components.

Shame has been conceptualised as a painful emotion that is trans-diagnostic in nature. Research has identified a positive association between religiosity and shame proneness (Chau et al., 1990; Luyten et al., 1998; Woein et al., 2003). Despite the significance of shame amongst SA women and its contribution to mental illness (Gilbert et al., 2004b), it is an area with limited research. Shame is the opposite of self-compassion that encourages one to be kind and compassionate towards oneself (Neff, 2003a). The current paper has identified how self-criticism activates shame in depression (Gilbert et al., 2006). As one continuously re-shames oneself, they have little self-reassurance and self-compassion (Gilbert et al., 2006). Those that are prone to self-criticism and have limited self-reassurance can benefit from being taught self-compassionate skills. Since spirituality has been associated with positive well-being (Smith et al., 2003a), a strong relationship between spirituality and self-compassion may be anticipated. On the other hand, orthodoxy may undermine self-compassion as it often depicts God in a judgemental way and humans may be perceived to be dependent on God.

There is evidence to suggest young women may be at risk of poor mental well-being.

Since women have expressed less self-compassion and are highly self-critical (Neff, 2003b), teaching them self-compassion skills may be crucial for well-being. Second generation SA women with greater religiosity may report more conflict within their intimate relationships (Inman, 2006). Given the mix of religious affiliations in Inman's (2006) study, it is difficult to tease apart the relationship between religion and relationship conflict.

If we consider evidence presented in this paper, we do not know to date how religiosity with shame and self-compassion presents in SA Muslim women. Future research is desperately needed in this area as the findings may inform us on how to engage better with Muslim women since they hesitate to access mental health services. Clinical psychology services have been criticised for being too Western and not providing appropriate services for minority groups (Department of Health, 2008; Williams, Turpin & Hardy, 2006). Since self-compassion is based on Eastern concepts (Neff et al., 2007), it may have potential to contribute to service provision. Psychologists may be able to increase self-compassion in emotionally distressed patients by teaching self-kindness and self-soothing skills. Consequently this may encourage self-acceptance and greater ability to tolerate unpleasant emotions. Spirituality and religious coping are significant amongst minority groups in managing psychological distress (O'Connor & Nazroo, 2002). Hence, self-compassionate skills may be consistent with cultural, religious and spiritual beliefs.

7. Conclusions

This paper has reviewed the literature on religiosity and its relationship with psychological well-being. It has emphasised the difficulties in defining and

measuring religiosity due to its multi-faceted nature. Research has established that spirituality and orthodoxy are associated yet distinct constructs (Piedemont et al., 2009). Religiosity has been measured in a variety of ways (e.g. service attendance, belief, religious salience) and associations with well-being have been positive and negative. It has been criticised since predominantly Christian samples have been used which limits generalizability. Religiosity has been established as a buffer against psychological distress (Maselko et al., 2009). Overall, Smith et al. (2003b) identified a moderate relationship between religiosity and depression of -.096 in a meta-analysis. The lack of consensus in defining and measuring religiosity has therefore obscured some of the outcomes of the studies. Through reviewing the religiosity literature, two components of religiosity were identified that contribute to well-being. Spirituality was found to positively impact well-being (Maselko et al., 2009; Smith et al., 2003a). The evidence for orthodoxy and its relationship with well-being yielded mixed findings. Orthodoxy has been found to have a negative impact on well-being where one may struggle to cope with an adverse life event (Pargament et al., 1998). In addition, orthodoxy has also been found to have a positive impact on well-being (Suhail & Chaudhry, 2004). We suggest that further research is needed to clarify these associations.

The latter part of this paper examined the literature on shame, that is commonly referred to as a painful self-conscious emotion (Tangney & Dearing, 2002). Shame has been established as a prominent emotion amongst SA women with mental illness (Gilbert et al., 2004b). Unfortunately there is limited research on shame in SA women. Evidence suggests that religiosity is associated with shame proneness (Chau et al., 1990; Luyten et al. 1998; Woein et al., 2003). Given the lack of research in this

area, we have identified that there are opportunities for further studies.

Attention was then drawn to self-compassion that includes self-kindness, being non-judgemental and accepting of the self (Neff, 2003a). It is therefore, opposite to shame. Women tend to be less self-compassionate than men (Neff, 2003b). To measure self-compassion and identify how it relates to shame, researchers have focused on self-criticism. Those that are highly self-critical are exposed to feelings of shame (Gilbert et al., 2004a), which is a significant feature of depression (Gilbert et al., 2006; Zuroff et al., 1999). Evidence suggests that those that are highly self-critical are prone to feelings of shame and are likely to have less self-reassurance, indicating poor self compassion.

The association between self-compassion and religiosity was then explored. Research by Neff (2003b) identified that Buddhists were more self-compassionate than undergraduates. No research to date has explored the relationship between religiosity and self-compassion. It is anticipated that spirituality and self-compassion may be highly related.

There is limited research on the relation between components of religiosity and well-being using non-Christian samples. There is minimal research on the relation between components of religiosity and shame in SA women, and no research on the relation between components of religiosity and self-compassion in SA women. Based on this literature review, we predict that, whereas orthodoxy will be related to higher levels of shame and lower levels of self-compassion, spirituality will be related to lower levels of shame and higher levels of self-compassion. Findings from future

studies will help add to the knowledge-base on how to engage better with SA women since they are reluctant to access mental health services.

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RELIGIOUS SPIRITUALITY AND ORTHODOXY AS PREDICTORS OF SHAME VS SELF-COMPASSION IN SOUTH ASIAN MUSLIM WOMEN

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Abstract

The aim of the present study was to identify how two forms of religiosity, orthodoxy and spirituality, relate to shame and self-compassion in South Asian (SA) Muslim women. Through qualitative methods we also aimed to understand how shame is conceptualised in this population. Sixty-seven women participated through completing self-report measures on orthodoxy, spirituality, shame and self-compassion. In addition, they all answered subjective questions about their experiences of shame. Four written transcripts were selected for analysis using Interpretative Phenomenological Analysis (IPA). Orthodoxy and spirituality were related yet distinct constructs. Shame negatively correlated with self-compassion. We identified no significant association between both forms of religiosity and shame. A significant negative correlation between orthodoxy and self-compassion was established. The transcripts revealed a process model of shame experience that may benefit clinical practice. Limitations of the study and recommendations for future research are discussed.

Key words: Religiosity, Spirituality, Orthodoxy, Shame, Self-Compassion, Well-being

Introduction

The role of religion in psychological well-being has been of long-standing interest to psychologists. Religiosity incorporates cognitive, emotional, behavioural and motivational elements concerning religion (Hackney & Sanders, 2003). Researchers have measured religiosity through religious behaviours (e.g. frequency of prayer and service attendance), religious salience (e.g. importance of religion) (Welch, Tittle & Grasmick, 2006), closeness to God, and religious or spiritual support (Hill, 2003). We draw a distinction between two components of religiosity: orthodoxy and spirituality. Orthodoxy refers to beliefs, rituals and practices that relate to a particular religious institution and involve social conventions (Miller & Thoresen, 1999). Orthodoxy resembles what Allport and Ross (1967) called pro-religiousness. For instance, an orthodox Muslim female may pray five times a day, wear a hijaab, eat halal meat, refrain from alcohol, fast during the holy month of Ramadan and believe that through following Allah's (God) teachings she will go to heaven. On the other hand, spirituality refers to the maintenance of a personal relationship with a deity or the universe (Piedmont & Leach, 2002). To demonstrate spirituality, one may strive to create meaning and purpose in their life that embraces a sense of connectedness (Pargament, 1997). For example, a Muslim female may maintain a personal relationship with Allah and gain mental strength to guide her through difficult times.

Empirical research has demonstrated how religiosity may positively and negatively impact one's psychological well-being. The present study aims to explore the relationship between religiosity and psychological well-being with a particular interest in South Asian (SA) Muslim females. Clinical psychology services have been criticised for being too Western and not providing appropriate services for

minority groups (Department of Health, 2008; Williams, Turpin & Hardy, 2006). Spirituality and religious coping are significant amongst minority groups in managing psychological distress (O'Connor & Nazroo, 2002). Therefore, the present study will strive to add to the knowledge base by investigating the relationship between religiosity and psychological well-being in SA Muslim women, with the hope to inform clinical psychology practice.

Religiosity and Psychological Well-Being

Generally there is greater research to emphasise the positive impact of religiosity in maintaining well-being. Although we propose spirituality and orthodoxy as two forms of religiosity, very few previous studies have made this distinction.

Religious service attendance has been associated with increased life satisfaction (Leondari & Gialamas, 2009) and 30% less chance of suffering from Major Depressive Episode (MDE; Maselko et al., 2009). Although it is useful to be able to identify religiosity as a buffer against depression, we do not know to what extent orthodoxy and spirituality contributed to these positive findings. Attending religious services is a behavioural activity that enables social networking, that may be significant in maintaining psychological well-being (Hall, Meador & Koenig, 2008).

Pargament et al. (1998) found that orthodoxy was a positive influence on well-being at times of psychological crisis. One is able to justify their experiences of distress and negative life events through religious means. Studies have predominantly used Christian samples that make it difficult to generalise findings to other religious affiliations (Smith, McCullough & Poll, 2003b). An exception is a study by Suhail

and Chaudhry (2004) that used a Pakistani Muslim sample. Their religiosity measure was designed specifically for Muslims. The items were about Islamic belief in one God (Allah), beliefs about the after-life and the prophet Mohammed. Additionally, the items measured religious practice that enquired about prayer, reading the Holy Quran, pilgrimage, giving to charity and living a life according to Islamic rules. Although the authors referred to it as a measure of religiosity, we identified it as a measure of orthodoxy since its items were consistent with the definition of orthodoxy. Their results revealed that orthodoxy contributed to maintaining a healthy well-being. The researchers note that orthodoxy was not the strongest predictor of well-being. Their findings indicated that work satisfaction and social support were more important than orthodoxy in maintaining positive well-being.

Studies have been able to identify how existential well-being may positively impact psychological well-being. Existential well-being refers to spirituality that encompasses meanings given to life and satisfaction with life (Maselko et al., 2009). Those with greater existential well-being are less likely to experience Major Depressive Episode (MDE; Maselko et al., 2009). To support Maselko et al.'s (2009) finding, existential well-being has been associated with positive religious coping (Pieper, 2004). Psychological well-being has been associated with positive religious coping in a highly religious in-patient sample (Pieper, 2004). Smith, Hardman, Richards and Fischer (2003) found that those presenting with greater spirituality benefited from better eating disorders outcomes. Women in this study were more positive about their relationship with food at post-treatment. Together these studies indicate the beneficial effects of spirituality on psychological well-being. To support these findings about spirituality being positive in maintaining mental well-being we

are able to draw from our own clinical experience.[11]

Case Example

Mrs X had recently lost her husband after he had a stroke. Although she was worried about living life without him, she claimed that having faith and believing in God would guide her through life. She thought that she was going through this difficult time for a reason and thinking about her life in this way gave it purpose and meaning that helped her remain psychologically strong.

Figure 1: Case example of Mrs X and spirituality

On the other hand, Maselko et al. (2009) identified that religiosity was associated with greater odds of presenting with MDE. Religious practice and prayer frequency has been associated with greater anxiety (Leondari & Gialamas, 2009; Pieper, 2004). Smith et al. (2003a) suggests that intrinsic religiosity and religious affiliation does not reduce mental health difficulties in women with eating disorders. Pargament et al. (1998) identified specific religious warning signs to be important in a mental health crisis. We identified these warning signs as an assessment of orthodoxy that may negatively impact psychological well-being. For example, individuals believed that they were being punished by their God when they experienced a negative life event. These individuals presented with greater anxiety and lower self-esteem. To illustrate this point further, we are able to draw from clinical experience again.[12]

[11] Refer to Figure One to view the case example of Mrs X that illustrates this point further.
[12] Refer to Figure Two to view the case example of Mrs Z.

Case Example

Mrs Z has schizophrenia, and a key feature of her illness is concerned with orthodoxy. She prays daily and believes that she experienced difficulties in her life because she had behaved badly and lost her God. Mrs Z fell pregnant out of wedlock and her son was taken away from her after birth. She strongly believes that this was a time in her life when she had lost her God and this experience is very shameful for her. She also claims that all the nurses on the ward are prostitutes as they have had sexual relationships and this is all wrong in God's eyes. Mrs Z believes that if she fails to follow God's teachings then bad things will happen to her and she will go to hell.

Figure 2: Case example of Mrs Z and orthodoxy

These findings indicate that religiosity and its orthodox component may have a negative impact on psychological well-being. These studies have highlighted the need for further investigation into the role of orthodoxy in mental well-being.

There is limited research with non-Christian samples that makes it difficult to gage the impact of religiosity on psychological well-being. An exception is a study by Inman (2006) who used a sample of South Asian women. Results showed that "very religious" women reported greater conflict within their intimate relationships. A generational difference was detected. Second generation women that considered themselves as "very religious" were prone to reporting greater conflict within their intimate relationships.

Summary

Research concerning religiosity and its positive impact on psychological well-being is more common than negative well-being. We propose that religiosity comprises of two components, spirituality and orthodoxy, that impact well-being in different ways. Very few previous studies have made the spirituality and orthodoxy distinction. Overall, spirituality has been identified as having a positive impact on well-being (Maselko et al., 2009; Smith et al., 2003a). In contrast, the findings concerning orthodoxy and psychological well-being yielded mixed results. For instance, Pargament et al. (1998) found that orthodoxy negatively impacted psychological well-being, where one may struggle to cope with an adverse life event and reach mental health crisis point (Pargament et al., 1998). One the other hand, Suhail and Chaudhry (2004) identified a positive association between orthodoxy and psychological well-being. These mixed findings suggest that further research is needed to clarify the relationship between orthodoxy and psychological well-being. Drawing on this evidence, we proposed that spirituality might be associated with positive outcomes, whereas religious orthodoxy might be related to more negative outcomes.

When negative well-being is broken down we can acknowledge that critical thinking and self-judgement are significant characteristics of emotional distress. Shame can be considered as a negative emotional construct and its maladaptive nature maintains psychological problems (Gilbert, 2000). Shame (negative) and self-compassion (positive) are indicators of psychological well-being. In the present study, we were curious to identify how shame relates to orthodoxy given its punitive nature, and how self-compassion may relate to spirituality given its forgiving quality. Previous studies

have not shown patterns of orthodoxy versus spirituality, possibly because of religiosity measures not identifying this distinction and well-being measures being too broad. Global well-being measures (e.g. depression) may fail to identify associations with spirituality and orthodoxy. The trans-diagnostic nature of shame may be more successful in relating to orthodoxy.

Shame

Shame is a negative self-conscious emotion that is experienced when one fails to adhere to a standard they have set themselves (Tangney & Dearing, 2002). Gruenewald, Dickerson and Kemeny (2007) describe shame as an emotional response concerning psychobiological reactions that initiate behavioural consequences (e.g. submission). Shame and guilt are negatively valenced, moral, self-conscious and self-referential emotions (Tangney & Dearing, 2002). At the same time, shame and guilt have their distinct identities. Guilt has been considered as adaptive, whereas shame has been understood as unhealthy and maladaptive (Tangney & Dearing, 2002). For example, shame proneness has been associated with personal distress (Leith & Baumeister, 1998), neuroticism (Johnson et al., 1987) and low self-esteem (Tangney, Burggraf & Wagner, 1995). In contrast guilt proneness has been related to empathic concern, perspective-taking and conventional morality (Leith & Baumeister, 1998; Tangney, 1991). Shame can be emotionally crippling if it is “internalised” and leads to evaluation of the entire self as dirty, hopeless or worthless. “Externalised” shame concerns how one is perceived by others (Gilbert, 1997) and experiences of stigma (Pinel, 1999). There is an urge to hide away as one is fearful about others finding out. “Internal” shame (Tangney et al., 1995) and “external” shame (Gilbert, Allan & Goss, 1996) have been associated with

depression. It has also been associated with anxiety (Gilbert, 2000) and Post-Traumatic Stress Disorder (PTSD; Lee, Scragg & Turner, 2001).

The role of shame in mental illness amongst SA women has been of great interest to psychologists (Gilbert, Gilbert & Sanghera, 2004b). When interpreting the increase in depression amongst SA women (Hussain & Cochrane, 2004), it is important to consider how shame may play a role in this. Research indicates that shame in SA cultures may be different to how shame has been traditionally defined in Western cultures. Tangney and Dearing (2002) suggest that shame is experienced as a result of one's own actions where one fails to meet a standard one has set oneself. In SA cultures, one can experience personal shame as a result of one's own behaviours but also bring shame onto others, for example one's family or community (Gilbert, 2002, Gilbert et al., 2004b).

Religiosity and Shame

Woein, Ernst, Patock-Peckham & Nagoshi (2003) found that greater shame was associated with poor psychological adjustment that supports Gilbert et al.'s (1996) findings. Chau, Johnson, Bowers, Darvill & Danko (1990) identified a positive correlation between shame and extrinsic religiosity. To support this, Woein et al. (2003) found a small correlation between shame and extrinsic religiosity. This small association indicates that when religion is utilised for social desirability purposes one may be somewhat more vulnerable to shameful experiences. To support these findings, Luyten, Corveleyn and Fontaine (1998) identified that religious involvement positively correlated with shame frequency and Test of Self-Conscious Affect (TOSCA; Tangney, Wagner & Gramzow, 1989) shame scores.

Self-Compassion

Self-compassion is a Buddhist psychology concept that focuses on acknowledging personal suffering. To be self-compassionate one must realise one's flaws and at the same time be non-judgemental and accepting of them (Neff, 2003a). The self-compassionate way of being is neatly embedded in "mindfulness" (Kabat-Zinn, 1994) that draws on the same principles of practising non-judgement and self-kindness. To achieve a mindful state, one must be self-compassionate. Self-compassion is a positive way of being that promotes emotional regulation (Leary, Tate, Adams, Allen, & Hancock, 2007). Research has identified that greater self-compassion benefits psychological well-being (Neff, Hsieh and Dejitterat, 2005) and adaptive psychological functioning (Neff, Kirkpatrick & Rude, 2007). In contrast shame is characterised by self-blame, self-criticism and internalisation of negative feelings (Gilbert, et al., 2004a). It is of no surprise that shame is considered as a maladaptive emotion (Tangney & Dearing, 2002) that can have a detrimental effect on psychological well-being (Johnson et al., 1987; Leith & Baumeister, 1998; Tangney et al., 1995). In this light, it is clear that shame and self-compassion are opposite to one another.

Essentially, self-compassion and shame both refer to the relationship one has with oneself. Those that are highly self-critical when they experience failure may have a "critical inner-dialogue" operating (Gilbert et al., 2004a). In these cases, shame is apparent as continuous self-criticism is experienced (Gilbert et al., 2004). This is an important point to note since depression includes features such as high self-criticism, negative thinking and limited self-reassurance (Gilbert, Baldwin, Irons, Baccus, & Palmer 2006). Together these characteristics indicate that there is an imbalance,

where the depressed mind set is prone to high self-criticism and low self-reassurance and self-compassion.

Self-Compassion and Religiosity

Neff (2003b) used the self-compassion scale and found that Buddhists presented with greater self-compassion than undergraduates. Neff did not assess the undergraduates' religious affiliations. Therefore it is unclear to what extent religiosity played a role in greater self-compassion. To date there is no research that has explored the relationship between religiosity and self-compassion. Therefore, there are great opportunities for further research. In doing this, it is important to consider how spirituality and orthodoxy relate to self-compassion to gain a better understanding.

Current Study

The objective of the current study was to understand the role of religiosity in psychological well-being in SA Muslim women. We differentiated between orthodoxy and spirituality and examined their respective associations with shame and self-compassion. We predicted that, whereas orthodoxy would be related to greater shame and lower self-compassion, spirituality would be related to lower shame and greater self-compassion.

Method

Ethical approval to conduct the present study was obtained by the University of Southampton, School of Psychology Ethics Committee (refer to Appendix One). The study included a quantitative and qualitative component.

Participants

Sixty seven Muslim females aged 19-30 years participated. A non-clinical sample was used. Participants were recruited using snowballing and convenience sampling. Professional female participants were used in this study. However, this study included a predominantly student sample who attended the University of Southampton and London universities. Psychology undergraduates from the University of Southampton received course credits for participation. Participants were also obtained through acquaintances and advertising the study's online link on a Psychology research website, www.onlinepsychresearch.co.uk. Non-English speakers were excluded from the study.

The age of participants ranged from 19 to 30 years (mean = 23.52, SD = 3.97). The birth place of the women in the study were predominantly UK with 74.6%, then Bangladesh with 6%, Pakistan with 4.5%, Saudi Arabia with 3%, and Brunei, Denmark, Germany, India, Iran, Kenya, Libya and Mozambique with 1.5% each. In terms of nationality, participants described themselves as British at 74.6%, and Bangladeshi, British Asian, British Bangladeshi, Indian and Pakistani at 3% each, and British Pakistani, Bruneian, Danish, Dutch, Kenyan, Portuguese and Swiss at 1.5% each. The sample consisted of Pakistani (43.3%), Bangladeshi (35.8%), Indian (13.4%), and Other Asian (7.5%). A total of 82.1% women attended school in the UK and 17.1% did not. Those that did not attend school in the UK, attended school in India and Pakistan at 3% each, and Brunei, Germany, Holland, Kenya, Norway, Saudi Arabia, Singapore and Switzerland at 1.5% each. A total of 95.5% attended higher education and 4.5% did not. Ninety-four percent attended higher education in the UK, and the remainder attended higher education in Norway, Pakistan and USA

at 1.5% each, and one participant did not respond. Women in this sample were highly educated as 31.3% had a Bachelor degree. "A" level and Master's degree qualifications were at 19.4% each, 14.9% had other qualifications and 7.5% had Doctorates. Six percent had a Diploma and 1.5% had GCSEs.

Measures

Participants completed a demographics questionnaire (refer to Appendix Two), a spirituality measure which was the Beliefs and Values Scale (King et al., 2005), a measure of orthodoxy from the Conceptual Systems Test (Gore, 1985; Harvey, White, Prather, Alter & Hoffmeister, 1966), the Self-Compassion Scale (Neff, 2003b), the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney, Dearing, Wagner & Gramzow, 2000) for shame proneness, and subjective questions about shameful experiences.

Spirituality Measure

The Beliefs and Values Scale (BVS; King et al., 2005)

This is a 20-item scale that assesses spirituality with items such as, "I am a spiritual person." Items were scored on a five-point Likert scale. The scale has a high test-retest and internal reliability. The scale achieved a Cronbach's alpha of 0.93. It has been tested on a range of ethnic and religious populations including Muslims from the Indian sub-continent. The authors tested it on a clinical sample of cancer patients, staff and students. Measures of religiosity have been criticised for failing to consider its relevance to diverse cultures, non-Christian religions, and for not using appropriate language (Hill, 2003). Therefore, the scale was adapted to include words that were specific to Islam. "Allah" replaced the word "God". Two items in the scale appeared quite similar ("I believe there is a God" and "I believe in a personal God").

In attempting to make this scale relevant to the SA Muslim population, the item "I believe in Allah" replaced the two similar items. Therefore, the final version of the scale consisted of 19 items. The current sample yielded an alpha level of .75 with this scale.

Orthodoxy Measure

Conceptual Systems Test (CST; Gore, 1985; Harvey et al., 1966)

Five items from the "Effectance via God" cluster in the Conceptual Systems Test (Gore, 1985; Harvey et al., 1966) were identified as a measure of orthodoxy. The measure included items such as "I believe I will succeed in life if I closely follow Allah's teachings." This measure was administered and items were scored on a five-point Likert scale. These items had a high alpha level of 0.96. Again the word "God" was replaced by "Allah" to suit the Muslim sample. The current sample yielded a Cronbach's alpha level of .91.

The Self-Compassion Scale (SCS; Neff, 2003b)

This measure consists of 26 items that focus on three aspects of self-compassion, (1) self-kindness, (2) common humanity and (3) mindful acceptance. All items are scored on a five-point Likert scale. An example of an item is: "I'm disapproving and judgmental about my own flaws and inadequacies". The SCS has excellent construct validity and test-retest validity of .93. Self-compassion correlated with self-esteem, yet the correlation was low enough to indicate they were distinct constructs (Neff, 2003b). The scale demonstrated that with greater self-compassion one is less anxious and less depressed even when trait self-esteem is partialled out (Neff, 2003b). In addition, the SCS does not correlate with social desirability. The current sample yielded an alpha level of .72.

Test of Self-Conscious Affect -3 (TOSCA-3; Tangney et al., 2000)

The TOSCA-3 measure was developed from written accounts of daily shame experiences. It consists of 16 items assessing people's imagined responses to hypothetical events. An example of an item is; "You break something at work and then hide it." The respondent must rate the following two statements on a five-point Likert scale. Statement one: "You would think: This is making me anxious and I need to either fix it or get someone else to." Statement two is: "You would think about quitting." The first response is indicative of guilt proneness, whereas the second response is indicative of shame proneness. In its original form, the TOSCA-3 assesses four constructs; shame, guilt, externalisation/detachment and pride. Only response options that are indicative of shame and guilt proneness were used for this study. TOSCA-3 has been validated and widely used in research. Wolf, Cohen, Panter and Insko (2009) detected an alpha level of .75 for the shame proneness subscale of the TOSCA-3. They also found that shame proneness correlated with neuroticism, personal distress and low self-esteem. The current sample generated a Cronbach's alpha of .82 for the shame proneness subscale of the TOSCA-3.

Qualitative: Experiences of Shame

The qualitative component of the study involved an investigation into the lived experiences of shame. The aim was to add meaning to experiences of shame and to understand the personal worlds of these female participants (Smith & Osborn, 2003). Interpretative Phenomenological Analysis (IPA, Smith, 1996) deemed the most appropriate methodology to be applied to the current study, since it strives to understand unique individual experiences (Smith, 2004). Data collection involved asking participants two subjective questions that asked about shame. Participants

were expected to respond with a written account. For debriefing purposes a final question was added but not analysed.

(1) What do you understand by the term “shame”?

(2) Please describe an experience where you felt shameful.

(3) Please describe an experience where you felt happy.

Procedure

An information sheet (refer to Appendix Three) stating the purpose of the study with a consent form (refer to Appendix Four) was provided prior to participation for ethical reasons. Confidentiality was assured throughout recruitment and data collection. The demographic questionnaire, all measures and subjective questions were all available online through the University of Southampton online research facility. Women participated in the study by either completing online questionnaires or hard copies. All participants were debriefed after they completed the survey (Appendix Five).

Qualitative Data Analysis

The process of data analysis for IPA adhered to Smith and Osborn’s (2003) methodology. Four cases were selected for analysis and each transcript was read through continually to become familiar with the data before noting emerging themes and clustering themes. Eventually sub-ordinate themes were identified that later formed part of the final super-ordinate themes. To validate analysis, triangulation was applied where an independent researcher also analysed the data. A collaborative approach was taken to agree on the interpretation of the data between both researchers.

Results

SPSS (version 17) was used to analyse quantitative data. The sample demonstrated a good level of power (.87) with 67 participants, significance tests at α =.05, an effect size f^2 =.15. For example, Cohen (1992) suggests a sample size of 67 for multiple regression with two predictors with α =.05, given a medium effect size.

The data were checked for normality and all variables except for orthodoxy violated the assumption for normality according to the Kolmogorov-Smirnov test. Orthodoxy was negatively skewed to the left (1.51) and its kurtosis was 2.80. We decided not to transform the data as all other three variables demonstrated a normal distribution. We thought the skewness of the orthodoxy variable showed an interesting finding, as it revealed that despite these participants being highly educated and predominantly growing up in a Western world, they still held orthodox values.

Correlations[13]

Spirituality and Orthodoxy

There was a significant positive correlation between the BVS (spirituality) and CST (orthodoxy), r (67) = .36, p < .003. This suggests that spirituality and orthodoxy are related, yet distinct constructs.

Shame and Self-Compassion

A significant negative correlation of r (67) = -.45, p < .000 between TOSCA shame and the SCS (self-compassion) was identified. This demonstrates that those presenting with greater shame are likely to be less self-compassionate.

[13] Refer to Table Four for correlation results

Religiosity and Shame

There was a non-significant correlation between the BVS (spirituality) and TOSCA shame, r (67) =.00, p < .974. There was a non-significant correlation between CST (orthodoxy) and the TOSCA shame, r (67) = .16, p < .209. Therefore, our hypothesis that orthodoxy would be related to greater shame was not confirmed, although the correlation was in the predicted direction.

Self-Compassion and Religiosity

A non-significant negative correlation between the BVS (spirituality) and the SCS (self-compassion) was found, r (67) = .182, p < .140. A significant negative correlation between the CST (orthodoxy) and the SCS (self-compassion) was established, r (67) = -.37, p < .002. Therefore, the hypothesis that orthodoxy relates to lower self-compassion was confirmed.

Table 4: Correlations for religiosity (spirituality and orthodoxy), shame and self-compassion

	M	*SD*	BVS	CST	TOSCA Shame	SCS
BVS	1.85	0.41	_			
CST	1.76	0.84	.363**	_		
Shame	2.94	0.59	.004	.156	_	
SCS	3.15	0.52	-.182	-.372**	-.454	_

Note: **p< .001 significant

M= mean, *SD*= standard deviation, BVS= Beliefs and Values Scale (spirituality),

CST= Conceptual Systems Test (orthodoxy), Shame= Test of Self-Conscious Affect Shame Subscale (shame), SCS= Self-Compassion Scale (self-compassion)

Regression Analysis

Religiosity and Shame[14]

Regression analysis demonstrated that 3% of the variance in shame was explained by the two religiosity measures, $R^2 = .03$, $F(2, 67) = .90$, $p < .42$. The analysis showed a positive non-significant association between the CST (orthodoxy) and TOSCA shame, $\beta = .18$, $p < .18$. Since the association was non-significant, our hypothesis that orthodoxy predicts greater shame was not confirmed, although the association was in the predicted direction. A weak non-significant negative association was detected between the BVS (spirituality) and the TOSCA shame, $\beta = -.06$, $p < .65$.

Table 5: Regression analysis for religiosity and shame (orthodoxy and spirituality)

Measure (Variable)	Beta	Standard Error (*SE*)	Standardised Beta (β)	*t* values	*p* values
CSS	.13	0.94	0.18	1.34	.18
BVS	-.09	0.19	-.06	-.46	.65

Note: R^2=, $F(2, 67) = .90$, $p < .01$

CSS= Conceptual Systems Scale (orthodoxy), BVS= Beliefs and Values Scale (spirituality).

[14] Refer to Table Five for shame and religiosity regression results.

Religiosity and Self-compassion [15]

Regression analysis was conducted and revealed that 14% of the variance in self-compassion was explained by the two religiosity measures, $R^2 = .14$, $F(2, 67) = 5.25$, $p < .01$. A weak non-significant negative association between the BVS (spirituality) and SCS (self-compassion) was detected, $\beta = -.06$, $p < .66$. Therefore, the hypothesis that higher spirituality may be associated with greater self-compassion was not supported. There was a significant negative association between the CST (orthodoxy) and the SCS (self-compassion), $\beta = -.35$, $p < .01$. Therefore, the hypothesis that orthodoxy is associated with less self-compassion was confirmed.

Table 6: Regression analysis for religiosity and self-compassion (orthodoxy and spirituality)

Measure (Variable)	Beta	Standard Error (*SE*)	Standardised Beta (β)	*t* values	*p* values
CST	-.21	.08	-.35	-2.83	.01
BVS	-.07	.16	-.06	-.44	.66

Note: $R^2 = .14$, $F(2, 67) = 5.25$, $p<.01$.

CST= Conceptual Systems Test (orthodoxy), BVS= Beliefs and Values Scale (spirituality)

[15] Refer to Table Six for self-compassion and religiosity regression results.

Experiences of Shame

The qualitative data was analysed according to Smith and Osborn's (2003) IPA methodology. Criteria for selecting four participants for analysis were based on how comprehensive their responses were in answering the questions. The four experiences of shame were (i) failing an exam, (ii) a pre-marital relationship, (iii) drinking alcohol and (iv) failing the first year of university. Analysis involved an initial descriptive summary and interpretations of the transcript. Whilst defining the term shame, participants also described their experiences of shame. Therefore, it deemed appropriate to present the results of both questions together rather than independently. After the transcript was re-read, emerging themes were noted to articulate identified concepts. It was always ensured that themes were embedded within transcripts. Connections between emerging themes were made to cluster themes that eventually enabled the identification of sub-ordinate themes. The final stages of the analysis involved developing super-ordinate themes made up of sub-ordinate themes. Each case was analysed independently in this way and finally five super-ordinate themes were identified that were representative of all transcripts. The five identified super-ordinate themes were (i) Identity (ii) Behaviour, (iii) Emotional consequences, (iv) Behavioural consequences and finally, (v) Cognitive reflection. All super-ordinate themes interacted and were salient features throughout the dataset. These interactions suggested a process was involved in experiencing shame that will now be explained in detail.[16]

(i) Identity

Identity included being a "woman", being "Muslim", being "Asian" and "culture".

[16] Refer to Figure Three for processing shameful experiences to view the relationship between the super-ordinate themes.

This sense of identity was characterised by personal (individual) and collective (family and/or community) expectations. Participant 13 described that expectations were set with the hope that one would refrain from "bringing shame on the family, disrespecting, acting selfishly in order to be happy. Doing something wrong in the eyes of others even though you think its ok. It's not for traditional families. Going out with the wrong man (not Muslim and/or wrong cast)." It appears that adhering to Islamic traditions by marrying a Muslim man is important, as is marrying within the same culture. Therefore, one is expected to consider their family, culture and religious affiliation in the way they live their life, that forms the collective expectations. Participant 39 explained, "As a Muslim woman if tomorrow I will insult someone from another religion I will feel shame on me for instance." This suggests that expectations of how to interact with those from other religious affiliations have been set by Islam.

Participant 15 stated, "I felt I had wronged my family not me." This statement supports Participant 13 who also drew the distinction between personal and collective expectations. For instance, what one believes to be right is not what the family or others may agree with.

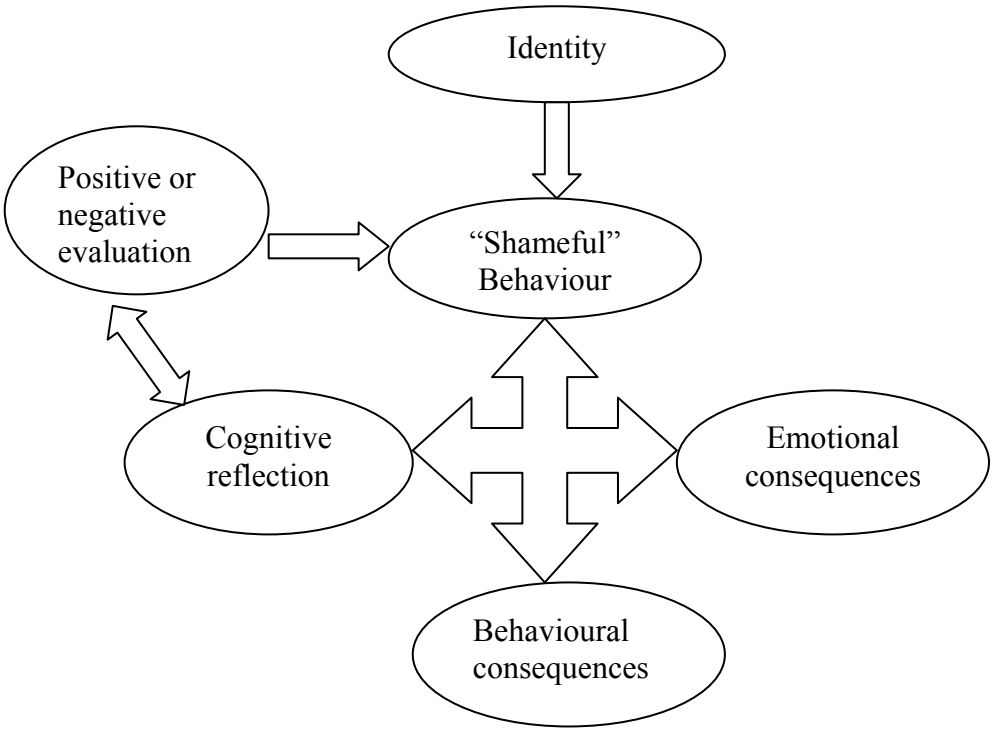

Figure 3: Processing experiences of shame

Personal expectations were characterised by "self-judgement" as described by Participant six who performed badly in an exam. A wide remit of responsibility accompanied these expectations, where she felt pressure to not let herself and her family down by performing badly in an exam. This was a common occurrence of standards and expectations of behaviours being set. Participant 39 who failed her first year at university also described the importance of "self-judgement". At the same time she expected her parents to judge her, yet they were "really supportive".

The transcripts reflected an internal struggle between personal and collective expectations. Should an individual go with their personal expectations that are not consistent with the collective expectations then they may be considered "selfish" and

"disrespectful" (Participant 13). Participant 13 described how she wanted control in her life and the only way to achieve this was to be selfish. She stated, "Well I will have to be selfish to make myself happy. I am not going to let people control me or my future."

(ii) Behaviour

Behaviours were brought about and determined by expectations. Behaviours were described as either intentional or unintentional that involved failing an exam, having a pre-marital relationship, having a relationship with a Muslim from a different culture. It appeared that behaviours inconsistent with orthodox Islam were reported as shameful. For example, "clubbing, wearing revealing clothes, smoking in public, drinking in public and generally engaging in western behaviours" (Participant 13). Therefore, these behaviours were not consistent with the collective expectations set for the individual.

(iii) Emotional Consequences

A distinction was made where all participants identified personal emotions and family emotions. One may feel that they have disappointed their family through their behaviours. Participant six described, "My parents were very disappointed with me." There is also a sense of personal disappointment that falls under personal emotions. All these emotions are accompanied with a high blame component and ownership of the behaviour that creates a distressing emotional experience. For example, "I knew it was my fault which is why I felt so shameful as I did not study for my exam" (Participant six). To support this, Participant 13 also stated, "it is my fault not anyone else's."

Participant 15 stated how “shame comes with a great deal of regret” and is a “negative emotion”. The transcripts reflected how the experiences were painful and distressing.

(v) Behavioural Consequences

Behavioural consequences of the original act may include the individual crying. “I cried the whole day” (Participant six). The individual may also feel inclined to want to hide away from others as they feel so emotionally distressed by their action. “I felt like disappearing that day” (Participant six).

(iv) Cognitive Reflection

Cognitive reflection is a process that occurs whilst the behaviour is being performed and after. During the initial stages of cognitively reflecting on the behaviour, one considers key features of their identity that include the family, culture, religion, and being a woman. It would seem from the narratives that participants then evaluated their behaviours as negative or positive. There is a huge blame component attached in appraising the behaviour where the individual accepts responsibility and owns the behaviour. For example, “I knew it was my fault which is why I felt so shameful as I did not study for my exam” (Participant six).

There is also emphasis placed on the family or community regulating control over one’s behaviour. “I did what I wanted to do and haven’t thought about what others will say to me or my family so I have bought shame on the family” (Participant 13). A distinction between personal and collective shame is made, where behaviours may be shameful for the family (collective) and may not necessarily be shameful for the

individual (personal).

A process was evident in positively or negatively appraising the behaviour. For instance, Participant 15 evaluated her experience of drinking alcohol as shameful. She added, “I’ve felt personal shame several times”. Therefore, this participant has experienced re-shaming that has been appraised in a negative way. In contrast, Participant 13 appraised her shameful experience positively. She took responsibility for her actions, acknowledged the difficulties of wanting to achieve happiness and the control the community and her family may have over her behaviour. Therefore, her response in appraising her behaviour was different to that of Participant 15. Participant 13 demonstrated a sense of self-compassion in her appraisal to the behaviour. She stated, “Well I will have to be selfish to make myself happy. I am not going to let people control me or my future even if I make a bad choice it is my fault not anyone else’s.” After negatively or positively appraising each shameful experience, participants may then continue to carry out further behaviours that may be evaluated as shame again.

Discussion

To our knowledge, this is the first study to investigate the relationship between components of religiosity, shame and self-compassion. The overall objective of this study was to identify how components of religiosity are related to psychological well-being in SA Muslim women. Orthodoxy and spirituality were distinguished as two forms of religiosity and their associations with shame and self-compassion were investigated.

Summary of Results

The results showed a moderate association between spirituality and orthodoxy that is consistent with the literature. Spirituality and orthodoxy, then, can be regarded as related, yet distinct aspects of religiosity. The significant negative correlation between shame and self-compassion was also in the hypothesised direction. That is, women with greater shame presented with less self-compassion. This finding is consistent with the idea that shame (negative) and self-compassion (positive) are indicators of psychological well-being.

The results demonstrated no support for the hypotheses concerning the relationships between orthodoxy and shame, and between spirituality and shame, as there were no significant correlations. The association between spirituality and self-compassion was negative and non-significant, a finding that was in the opposite direction to what was hypothesised. The most significant association was the negative correlation between orthodoxy and self-compassion. Our hypothesis was confirmed and suggested that women who were more orthodox were less self-compassionate. In regression analyses, orthodoxy was the strongest predictor of self-compassion. These results indicate that women who are more orthodox are likely to be less self-compassionate.

Summary of Qualitative Results

Four cases were selected for analysis and respondents described shame experiences that entailed failing an exam, a pre-marital relationship, drinking alcohol and failing the first year at university. IPA results identified super-ordinate themes that were representative of the four chosen cases. The five super-ordinate themes were identity,

behaviour, emotional consequences, behavioural consequences and cognitive reflection. These super-ordinate themes were recognised to be interacting with one another that suggested a process model for shame experiences amongst SA Muslim women.

Discussion of Findings

The association and distinction between spirituality and orthodoxy supports Piedmont, Ciarrochi, Dy-Liacco and Williams (2009) findings. They found that orthodoxy and spirituality correlated, yet demonstrated unique variance. This adds further evidence to the argument made by other researchers that spirituality and orthodoxy are related, yet at the same time are distinct constructs. Our study demonstrates that the association between spirituality and orthodoxy is not confined to Christian samples. We recommend that it may be beneficial to assess spirituality and orthodoxy together in order to ensure accurate measurement of religiosity, since orthodoxy and spirituality are related and unique constructs.

Our results revealed that women with greater shame were less self-compassionate. Shame and self-compassion both reflect the relationship one has with oneself. Ultimately, shame involves being highly self-critical (Gilbert et al., 2004a), whereas self-compassion involved being non-judgemental regarding the self (Neff, 2003a).

The finding that there was no significant association between both forms of religiosity and shame was surprising. Perhaps shame was not measured adequately with the TOSCA, since it is based on Western cultures where shame is experienced as a result of one's own actions when one fails to meet standards one has set oneself.

In SA cultures, one can experience personal shame as a result of one's own behaviours but also bring shame onto others, for example one's family or community (Gilbert, 2002, Gilbert et al., 2004b). Another explanation for this unexpected finding may be that religiosity suppresses experiences of shame. That is, women may be using their religion as a way of not allowing themselves to experience shame. Furthermore, our sample comprised of highly educated women. They may have developed a sense of independent identity if they lived away from home to attend university and have more ability to critically evaluate their relationship with religion in relation to experiences of shame.

Our most striking findings concerned the relationship between orthodoxy and self-compassion, where orthodox women tended to be less self-compassionate. Our hypothesis was confirmed and it is an addition to the literature, since the relation between orthodoxy and self-compassion has not been studied to date. These findings support Pargament et al.'s (1998) finding that orthodoxy has a negative impact on well-being when one is experiencing a mental health crisis. This may suggest that these women may be using their religious identity as a way of coping with difficulties they may face throughout life. They may believe that rather than being kind to oneself to achieve happiness, it may be more beneficial to identify with Islam. They may be motivated to be this way as a common belief amongst Muslims is that they will be rewarded in the afterlife if they suffer in the present life (Rozario, 2009). Our results indicate that women with greater orthodoxy run the risk of having a negative relationship with themselves. That is, since these women are less self-compassionate they may be less accepting of their flaws, judge and criticise themselves (Neff, 2003a). If women continue to present with low self-compassion,

then they may be falling into the trap of being highly self-critical and lack self-reassurance and self-soothing skills (Gilbert & Procter, 2006).

Qualitative Findings

Our qualitative findings enabled us to develop a process model for SA Muslim women experiencing shame. The emotional consequences of feeling disappointment and letting themselves and significant others down is also in keeping with what other researchers have claimed (Tangney, 1992). The behavioural consequences described by the women were consistent with previous research in that the shameful experience was distressing and created tearfulness and a desire to hide away (Tangney, 1992).

It is apparent that identity is a key component in initiating the shame experience. Women disclosed how their identity was driven by gender, religion and culture that were characterised by personal and collective expectations of how one should live their life. These findings are coherent with literature that states ethnicity or religion is a key identity marker (Rapoport, 1981). For Muslims in the Western world, religion remains a key identity marker and it is irrelevant to how religious they consider themselves (Roald, 2001).

Women in the present study articulated shame to be related to family honour that is in keeping with Gilbert et al.'s (2004b) findings. Like Gilbert et al. (2004b) established culture was a significant feature throughout the experience of shame. For example, Participant 13 described her experiences of pre-marital dating would be frowned upon by her family and the community despite him being Muslim but from a different culture. Dhruvarajan (1993) identified that religiosity related to patriarchal

views, dissatisfaction with inter-racial marriages and little tolerance with pre-marital dating. To put our findings into context it may be useful to consider generational differences in cultural and religious conflicts. First generation women fear their ethnic social structure would be compromised if behaviours such as pre-marital intimacy became public knowledge (Inman, Ladany, Constantine & Morano, 2001). Whereas women in the present study expressed shame would be experienced if they were seen to be engaging in generally "Western behaviours" such as "drinking, smoking and wearing revealing clothing" (Participant 13). Inman et al.'s (2001) findings that second generation women tend to fear losing integrity within the community if they are seen as "too American" may lend support to our results. Our findings identified that an internal struggle was experienced given the discrepancy between how these women wanted to live their life and family expectations that were fuelled by cultural and religious traditions. This constant internal struggle may be unhealthy and initiate stress. For instance, Inman et al. (2001) found that second generation women often experienced greater stress as their parents fear they may become "too Americanised" and closely observe their behaviours. Clinical psychologists would be curious about how these women cope with the internal struggle and manage the distress it may initiate. Further research would be beneficial in exploring this in detail.

Culture and religion are so entwined in the SA population (Sonuga-Barke & Mistry, 2000) that it is difficult to tease them apart when attempting to understand the relationship between shame and religiosity. In collectivist cultures emotions are linked to how behaviours reflect on others and in individualistic cultures emotions are related to reflections on the self (Mesquita, 2001). The cases included in this

study demonstrated a distinction between personal emotions and family emotions. The experience of shame was characterised by an internal struggle where one may feel pressure to conform to their family, cultural and religious norms whilst also feeling torn in wanting to be personally happy. Therefore, shame as an emotional experience is conceptualised in a way that is consistent with Mesquita's (2001) theory about collectivist cultures.

Clinical Implications

The present study's findings add to the knowledge base in attempting to understand how religiosity, shame and self-compassion relate and present in SA Muslim women. Since SA women are reluctant to engage with psychological services, this study is an attempt in gaining insight into engaging better with this hard to reach group. One of the main findings indicates that orthodoxy relates to lower self-compassion. Greater orthodoxy may be a risk factor for women that are highly self-critical, in that they may be dealing with their experiences of failure in a maladaptive way. These women may be using their religious practices as a way of managing distress more frequently than applying psychological skills to manage difficulties. Clinical psychology offers opportunities for these women to learn and master self-compassionate skills to self-soothe rather than self-attack when they experience emotional distress (Harman & Lee, 2010).

Since clinical psychology has been criticised for being too Western (Department of Health, 2008; Williams et al., 2006) it is important that creativity is used to its full potential to contribute to service provision. In working through these emotional experiences, it is important that a culturally sensitive approach is taken that is

mindful of not offending and at the same time respecting cultural and religious beliefs and values. The model of shame process for SA Muslim women introduced in this study is suitable for clinical practice since it is consistent with the Cognitive-Behavioural Therapy (CBT) model. The model breaks down the experience of shame that enables clinicians to focus on tackling each area. For instance, the cognitive reflection component in the model has ample scope for identifying how individuals cognitively appraise their shame experience. Cognitive therapy may be beneficial in exploring alterative ways of appraising the shame experience so that it creates less emotional pain. Behavioural consequences of experiencing shame may also be modified in that women may be taught self-compassionate skills rather than feeling desperate to hide away and avoid situations.

Limitations of Study and Recommendations for Future Research

We did not transform the orthodoxy variable despite it violating Kolmogorov-Smirnov's normality assumption. We thought the skewness of the orthodoxy variable was interesting and that it may be a true reflection of the SA Muslim female population. Despite the high level of education and exposure to Western norms, these women maintained a strong orthodox identity. This finding may be consistent with Roald's (2001) suggestion that religion is a key identity marker for Muslim women living in Western society.

Since orthodoxy relates to lower self-compassion, it may be beneficial for future research to measure locus of control. In that external locus of control may convey that God may be responsible for solving difficulties (Rotter, 1966). By contrast, internal locus of control suggests one must take personal responsibility for one's

difficulties (Rotter, 1966) and perhaps through self-compassion one may be in a better frame of mind to problem-solve.

Religion and culture are deemed to be fairly entwined in SA culture, making it challenging to interpret our findings. No acculturation measure was used in the present study. If future research uses an acculturation measure along with spirituality and orthodoxy then we may be in a better position to identify how religiosity relates to shame and self-compassion. We did not include a control group in the present study. It may be beneficial for future research to compare SA Muslim women to another religious affiliation. For instance, Sonuga-Barke and Mistry (2000) established that Muslim women presented with greater levels of depression than Hindu women. It is unclear to what extent religiosity plays a role in their depression and a comparison study may help explore this finding.

Our qualitative findings identified a distinction between individualist and collectivist shame that is consistent with Gilbert (2002). Therefore, we wonder how appropriate the TOSCA shame scale was to use in the present study given that it is based on the individualist model of shame. Our study highlights the need for the development of a shame scale that is appropriate for Muslim women and considers the individualist and collectivist distinction.

Our findings demonstrated that in relation to shame, women experienced an internal struggle in how they wanted to live their life that was complicated by family, culture and religion. It may be beneficial for future research to assess depression and anxiety to establish to what extent emotional distress is experienced.

Conclusions

The present study aimed to identify how two forms of religiosity; orthodoxy and spirituality relate to shame and self-compassion in SA Muslim women. In addition, we aimed to understand how the experience of shame is conceptualised in SA Muslim women using qualitative methodology. We identified that orthodoxy and spirituality were related yet distinct constructs. Greater shame associated with lower self-compassion. There was no significant association between both forms of religiosity and shame, thus our first hypothesis was not supported. The second hypothesis was confirmed in that women with greater orthodoxy tended to be less self-compassionate. We acknowledge that culture may have played a role in these findings and it is important that future research assesses acculturation. We recommend that a shame scale that is based on collectivist cultures is developed to ensure that shame is being assessed adequately in non-Western samples. Our qualitative findings enabled the development of a process model for shame experiences in SA Muslim women that may be useful in clinical practice since it follows the CBT framework. Overall the study demonstrates that a specific component of religiosity, namely orthodoxy, may be an important predictor of psychological well-being, in particular reduced self-compassion, in SA Muslim women.

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Appendix One: Ethical Approval

UNIVERSITY OF Southampton

Miss Deba Choudhury
School of Psychology
University of Southampton
Bassett Crescent East
Southampton
SO16 7PX

RGO Ref: 5985

18 March 2009

Dear Miss Choudhury

Project Title **Religiosity in South Asian Muslim Women and Their Proneness to Shame and Self-Compassion**

This is to confirm the University of Southampton is prepared to act as Research Sponsor for this study, and the work detailed in the protocol/study outline will be covered by the University of Southampton insurance programme.

As the sponsor's representative for the University this office is tasked with:

1. Ensuring the researcher has obtained the necessary approvals for the study
2. Monitoring the conduct of the study
3. Registering and resolving any complaints arising from the study

As the researcher you are responsible for the conduct of the study and you are expected to:

1. Ensure the study is conducted as described in the protocol/study outline approved by this office
2. Advise this office of any change to the protocol, methodology, study documents, research team, participant numbers or start/end date of the study
3. Report to this office as soon as possible any concern, complaint or adverse event arising from the study

Failure to do any of the above may invalidate the insurance agreement and/or affect sponsorship of your study i.e. suspension or even withdrawal.

On receipt of this letter you may commence your research but please be aware other approvals may be required by the host organisation if your research takes place outside the University. It is your responsibility to check with the host organisation and obtain the appropriate approvals before recruitment is underway in that location.

May I take this opportunity to wish you every success for your research.

Yours sincerely

Dr Lindy Dalen
Research Governance Manager

Tel: 023 8059 5058
email: rgoinfo@soton.ac.uk

Corporate Services, University of Southampton, Highfield Campus, Southampton SO17 1BJ United Kingdom
Tel: +44 (0) 23 8059 4684 Fax: +44 (0) 23 8059 5781 www.southampton.ac.uk

Appendix Two: Demographics Questionnaire

Please tick the appropriate boxes or write your response where relevant.

Place of birth (including country): …….

If you were not born in the UK then how long have you lived in the UK?

…… years

Date of birth: ……..

What is your nationality? …….

Please tick which best describes your ethnicity

Asian or Asian British

Indian []
Pakistani []
Bangladeshi []
Other Asian []

Mixed

White & Asian []
Other Mixed []

What is your marital status?

Single []
Cohabiting []
Married []
Divorced []
Widowed []

Did you go to school in the UK? Yes [] No []

If not then where did you go to school? …….

Did you go to college/university? Yes [] No []

If so then did you attend college/university in the UK? Yes [] No []

If not in the UK then where did you study? …….

What is your highest level of study?

GCSE	[]
A level	[]
Diploma	[]
Bachelor	[]
Masters	[]
Educational specialist	[]
Ph.D., D.Clin Psych or Ed. D,	[]
Other	[]

Appendix Three: Participant Information Sheet

Researcher: Deba Choudhury
Ethics number:

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to complete a consent form.

What is the research about?
I am Deba Choudhury (Trainee Clinical Psychologist). I am currently undertaking research for my Doctorate in Clinical Psychology, and interested in how South Asian Muslim females with different personalities process social situations, how this is related with different attitudes and well-being.

Why have I been chosen?
I am interested in hearing from you if you are a South Asian female aged between 18 and 30 years of age.

What will happen to me if I take part?
By taking part in the study, you will be asked to complete four questionnaires (demographic, religiosity, shame and self-compassion) and write about a shame experience. It should take approximately 30 minutes to participate in the study. Your name or any other identifiers will remain confidential.

Are there any benefits in my taking part?
Should you decide to participate in the study then it will help us understand the role of personality variables in processing social situations. The findings of the study may help us understand how to improve psychological treatment for South Asian Muslim females, as there are very few who access the health care system.

Are there any risks involved?
There are no risks involved for you by taking part in this study.

Will my participation be confidential?
In compliance with the Data Protection Act and University policy, your name and responses to the questionnaires will remain confidential. Data will be stored in a locked filing cabinet and on a password-protected computer.

What happens if I change my mind?
You are free to withdraw from the study at any time without negative consequences.

What happens if something goes wrong?
In the unlikely case of concern or complaint, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

Where can I get more information?
If you would like further information or have some questions about the study then you may contact me on dc4v07@soton.ac.uk.

Appendix Four: Consent Form

I am Deba Choudhury (Trainee Clinical Psychologist). For my Doctorate in Clinical Psychology Dissertation, I am currently undertaking a study investigating how South Asian Muslim females with different personalities process social situations, how this is related with different attitudes and well-being.

I am requesting your participation in the study, which will involve you completing four questionnaires (demographic, shame measure, values and beliefs and self-compassion). Finally there will be some open questions that will ask you to think about shame experiences. It should take you no longer than 30 minutes to complete all questionnaires. Your opinions will be very valuable in understanding how South Asian women with different personalities process social situations, which has not been previously researched. Personal information will not be released to or viewed by anyone other than researchers involved in this study. Results of this study will not include your name or any other identifying characteristics.

Please complete your name, date of birth and contact details below so that we have a record of your informed consent as a participant in this study, for your data to be used for the purposes of research, and that you understand that published results of this research project will maintain your confidentially. Your participation is voluntary and you may withdraw your participation at any time.

If you would like a summary of this research project or have any questions/queries then please contact me by email: dc4v07@soton.ac.uk. If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

Participants name: ……

Date of Birth: …….

*Email contact: ……

*Telephone contact: …….

* Please note, your contact details will only be used if it is necessary for us to contact you for any clarification needed.

Appendix Five: Debriefing Statement

The aim of this research was to explore the role of shame in South Asian Muslim women by understanding how religiosity, self-compassion and shame proneness may be involved in explaining how shame is understood.

Your data will help our understanding of how to engage better with South Asian Muslim females who may be experiencing psychological distress. Once again results of this study will not include your name or any other identifying characteristics. The research did not use deception. You may have a copy of the summary of the findings if you wish upon request.

If after participating in the study, you feel emotionally distressed in anyway then please do not hesitate to contact the Samaritans on 08457 90 90 90 or email them on jo@samaritans.org.

If you have any further questions please contact me Deba Choudhury by email: dc4v07@soton.ac.uk.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

Thank you for your participation in this research.