Psychology of Religion and Spirituality

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Online First Publication, November 13, 2023. https://dx.doi.org/10.1037/rel0000511

AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychology of Religion and Spirituality

ISSN: 1941-1022

https://doi.org/10.1037/rel0000511

The Experiences of Faith and Church Community Among Christian Adults With Mental Illness: A Qualitative Metasynthesis

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Mental illness within Christian communities may be subject to stigmatization, with some attributing it to demonic possession, lack of faith, personal sin, or other negative spiritual influences. Contrasting research, however, suggests a potentially supportive role, in that Christian faith and community may aid recovery from mental illness and/or act as a buffer against onset or relapse. The aim of this qualitative review was to systematically collate and characterize published qualitative evidence that explores the experiences of adult Christians with mental illness in relation to their faith and community. An electronic search of 15 databases was conducted, alongside the manual review of notable journals in the area and expert consultation. Twenty-two studies were included from 12,607 reviewed articles. A thematic synthesis identified four higher level themes: *positive experiences of Christian communities* (subthemes: *congregational support*; *faith leaders and pastoral care*), *positive coping through Christian meaning systems* (subthemes: *religious meaning-making*; *positive coping through relationship with God*), *negative experiences of Christian communities* (subthemes: *imposed spiritualization of mental illness*; *stigma, exclusion, and marginalization*), *difficulties navigating faith amid suffering* (subthemes: *dissonance: mental illness and faith*; *negative affect*). This qualitative systematic review provides support to the vital importance of Christian faith and community for Christians who experience mental illness. It categorizes the idiographic and often diverse ways in which Christians living with mental illness may experience their faith and church community and explores how Christian religious systems and communities may function to support or hinder experiences of mental illness.

Keywords: Christian, mental illness, experiences, qualitative, metasynthesis

Supplemental materials: https://doi.org/10.1037/rel0000511.supp

The relationship between Christianity and mental illness is complex and variable. While some have suggested that Christian communities may stigmatize those who suffer with mental illness, others have suggested a potentially supportive role of the Christian faith in supporting psychological well-being and recovery from psychological distress. We sought to capture the complexity of this relationship by systematically collating and characterizing published qualitative studies exploring the experiences of adult Christians with mental illness in relation to their faith and community.

Mental illness refers to conditions that have a significant impact on individuals' daily living, owing to changes in one's emotions, styles of thinking, and behavior (Galderisi et al., 2017). Mental illnesses vary in intensity ranging from no significant impairment in daily living to severe debilitation (e.g., Bowins, 2015). Using data from Argentina (Cía et al., 2018), it has been estimated that more than one in 10 people suffer from a mental illness in any given year in which the lifetime risk for being diagnosed with any condition of mental illness is around 40% (Global Burden of Diseases 2019 Mental Disorders Collaborators, 2022). Longitudinal projections have also suggested that rates of self-disclosed mental illness are increasing year on year, placing further strain on individuals, family members, and health care provision (Richter et al., 2019). As such, understanding mental health has become a major focus for researchers, policymakers, and practitioners alike.

Although the various causes of mental illness are subject to debate, many accept that most mental illnesses will have biological, psychological, and social components (Gask, 2018). While there are certainly existing pharmaceutical treatments to help support people living with mental illness, research has shown that many people are treatment-resistant and that the efficacy of drug treatments is often rather low (Leichsenring et al., 2022). As for psychological and

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No funding was received for conducting this study. The authors have no competing interests to declare that are relevant to the content of this article.

Open Access funding provided by University of Westminster:

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therapeutic interventions, many find it difficult to access services due to long waiting lists, economic barriers, and stigma (Schaffler et al., 2022). As a result, a growing body of literature has begun to focus on the sociological determinants of mental well-being and the behaviors that seem to support mental health.

Two such sociological determinants are spirituality and religion, which both have clear importance in defining an individual's identity and worldview (Brandt, 2019). Within health care specifically, spirituality and religion may play an important role for some because they provide a source of meaning-making, hope, and a lens through which to understand suffering (Garssen et al., 2021). Accordingly, there have been important developments concerning policy and good practice in the provision of mental health care to account for the role of social identity, including spirituality and religiosity (Oman & Brown, 2018). It is now considered important to take a person-centered and holistic approach to understanding the experiences and needs of individuals living with mental illness; this includes aspects such as how their faith influences their lived experience and understanding (Page et al., 2020). Indeed, it is now common practice to gauge the qualitative aspects of living with mental health concerns, including experiences of hope, changes to one's identity, and meaning, alongside the biological and pharmaceutical frameworks of mental illness.

Despite challenges in defining spirituality and religion, the former is often understood to refer to a group of behaviors in which individuals pursue a personalized approach in finding connection, meaning, and purpose in life (Austin et al., 2018). Religiosity, on the other hand, while similar in its goals to spirituality, is often more systematic and less personalized (Austin et al., 2018). This is because being religious implicates predetermined theological frameworks through which people are permitted or prohibited to find such meaning. Such frameworks may include the reading of validated and accepted scriptures, participating in liturgical worship, and praying to God(s) through recognized prayers. Across the globe, a nonnegligible number of people have spiritual or religious beliefs that impact the way in which they see the world and, by extension, understand experiences of health and illness.

As for religiosity, much research has shown that increasing commitment to religion is associated with better health outcomes (Shattuck & Muehlenbein, 2020). This has included lower levels of self-reported depression (Forouhari et al., 2019), anxiety (Abdel-Khalek et al., 2019), and personality disorders (Buzdar et al., 2019), in addition to higher rates of well-being (Hoogeveen et al., 2022), gratitude (Watkins et al., 2022), hope (Counted et al., 2022), and supportive connections with God and others (Lloyd & Reid, 2022). That being said, an existing body of research has also suggested that religious individuals are possibly less likely to come forward for mental health help when facing psychological difficulties (Lloyd et al., 2021; Lloyd & Kotera, 2021). It has been suggested that religious individuals with fundamentalist beliefs are more likely to see mental illness as the outcome of a poorer relationship with God, sinful living, or demonic activity (Lloyd et al., 2022; Lloyd & Panagopoulos, 2023). Thus, within the context of such a conceptualization of mental illness, there is also evidence of religious stigma toward mental illness, despite the fact that mental illness is found to be reported less prevalently within religious communities.

That being said, research has suggested that health outcomes differ across religious affiliations, necessitating an understanding of religion-specific relationships with well-being (e.g., Aksoy et al., 2022; Villani et al., 2019). Current estimates suggest that Christianity is the world's largest religion with the largest number of self-identified adherents, motivating the current article to focus specifically on well-being within Christian communities (Hackett & McClendon, 2017).

Although there exist many denominations within Christianity, the general precepts for most Christians are that they believe in the incarnation of God in the person of Jesus Christ, divine inspiration in the writing of biblical texts, and an afterlife promised to those who walk in good faith in the sacrifice of Jesus on the cross for the forgiveness of sins (Noll et al., 2019; Stanford & McAlister, 2008). The mechanisms through which Christianity may support mental well-being, while at other times being associated with poor psychiatric outcomes, are qualitatively complex and difficult to capture within a reductionist and quantitative scientific framework. While it is possible that Christianity permits individuals to reinterpret life difficulties and thereby buffer the impact of stress on mental well-being, it is also possible that Christianity poses significant challenges concerning mental illness (Adams et al., 2018; Lloyd & Waller, 2020). For example, research has shown that Christianity is also associated with excessive guilt, rejection within the religious community, and stigma when experiencing spiritual and mental illness (Harris et al., 2021). Within an increasingly postreligious world, it is also possible that Christians may experience the benefits of faith on their well-being within the Christian community while experiencing stigma from the wider world. This may explain why Christianity is sometimes associated with poorer well-being outcomes. Consequently, much care is required when studying the relationship between mental well-being and Christianity to capture the complexity, dimensionality, and dynamic nature of the religious construct. Thus, while quantitative research has shed much light on the complex relationship between Christian belief and well-being, the most thorough understanding of the association between health and Christianity is likely to be garnered by exploring the lived experiences of individuals, which are nuanced, detailed, and personal.

Systematic reviews of qualitative studies are one such method of capturing a more comprehensive understanding of complex social constructs across a wide range of contexts. Qualitative syntheses permit researchers to aggregate complex thematic data across primary studies, drawing findings together, which may uncover new understandings of how and why Christian belief relates to diverse health outcomes in adherents. By looking at where the constructs of Christianity and well-being converge or diverge across primary studies, qualitative syntheses could support the development of new theory and uncover new hypotheses to be tested with quantitative designs. Recently, a qualitative metasynthesis by Milner et al. (2020) took this approach in capturing the experiences of spirituality in individuals living with mental illness. Yet acknowledging the differences between spirituality and religion outlined above, there has been no such qualitative metasynthesis to date to systematically collate studies that have explored how Christians with mental illness perceive the role of their faith and wider church community. As such, we aimed in this review to systematically identify, collate, and discuss emerging themes from qualitative studies looking at the experiences of mental health in Christian communities specifically.

Method

Research Design

Various methods of conducting systematic reviews of qualitative studies have been proposed in the literature, outlining approaches to integrating and interpreting qualitative findings. In this article, we followed the five-step structured approach of Gewurtz et al. (2008): (a) We developed a research question that considered breadth, wherein the research topic could be sufficiently explored, and focused, such that the process of synthesis remained manageable; the research question asked: *What are the experiences and perceptions of mental health in the context of Christian church community and faith?* (b) We outlined inclusion and exclusion criteria to collect relevant and comparable findings. (c) We identified studies primarily through database searches, which we supplemented by manual searches and by consulting two field experts to ensure all relevant literature was identified. (d) We assessed the quality of the identified studies using the Critical Appraisal Skills Programme (2018). (e) We synthesized the findings of the identified studies through inductive comparison and translation by way of thematic analysis (Braun & Clarke, 2006; Thomas & Harden, 2008). As per Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines, we preregistered this study on The International Prospective Register of Systematic Reviews (CRD42022340437) in June 2022.

Reflexivity and Researcher Description

Qualitative research places significant importance on researchers' backgrounds in approaching the study, emphasizing the need for transparency between researchers' own subjective experience, expertise, and motivation for conducting a study, and how this necessarily shapes academic research. This includes researchers' own experiences, values, and assumptions (Swinton, 2001). The first author (CL) is a Christian, psychologist, and qualitative researcher and thus brings an intersectional standpoint to the topic of Christianity and mental health. He was raised in a Pentecostal Evangelical Christian home and grew up with direct and intimate knowledge and experience of this faith community. His childhood experiences of faith emphasized the mystical and spiritual realm in a way that he now feels represents an extreme and unhelpful response, especially regarding mental and physical illness. As an academic and psychologist, he now conducts research that aims to bridge the gap between the two historically antithetical fields (Bergin, 1991), thus attempting to support a holistic understanding of mental health for both the secular and Christian communities. The second author (JC) is an early-career psychologist and was raised in a Presbyterian Christian home. His father is a Church of Scotland minister. Though no longer practicing, he has lived experience of having faith and being part of a church community and is academically interested in religious communities and spaces as social resources. The third author (MCP) is a practicing Christian and academic whose research is focused on the psychology of religion. She was brought up in an Evangelical community in South Africa and holds an understanding of the language used by Christians. Her research is focused on qualitatively investigating the spiritual experiences of Christian communities. The fourth author (GR) is an academic researcher whose work focuses primarily on modifiable risk factors for age-related neuropsychiatric pathologies. He was raised in a loosely agnostic household with some cultural influences of Roman Catholicism. As an adult, GR formally converted to Roman Catholicism through the church's year-long process of the Rite of Christian Initiation of Adults, having explored many denominations of Christianity as well as other religious traditions. As such, he has been explicitly instructed in Roman Catholic doctrine, giving him both a theological understanding and lived experience of the faith that he brings to this research. GR now identifies as agnostic but maintains his personal and academic interest and engagement with Christian communities, as well as religious traditions more generally.

Eligibility Criteria

We considered studies for inclusion in our systematic review if they had a qualitative design and discussed the experiences and perceptions of faith and religious community among Christian adults with mental health difficulties. We limited the scope of our search to articles written in English and published in peer-reviewed journals, excluding any gray literature, such as conference abstracts, poster presentations, or theses. See Supplemental Table S1 for an outline of the exclusion criteria.

Search Strategy and Information Sources

We conducted our search on 15 online databases. We searched six databases (Anthropology Plus, APA PsycArticles, APA PsycInfo, Atla Religion Database, CINAHL, and Psychology and Behavioral Sciences Collection) from 1965 to July 2022 via EBSCO. We searched nine databases (BIOSIS Citation Index, BIOSIS Previews, Current Contents Connect, Chinese Science Citation Database, Data Citation Index, KCI-Korean Journal Database, MEDLINE, SciELO Citation Index, Web of Science Core Collection) from 1933 to July 2022 via Web of Science. Using the search terms in Supplemental Table S2, we added the identified articles (n = 13,004) to EndNote and removed duplicates (n = 397). Two reviewers then independently screened the titles and abstracts (n = 12,607) against the inclusion criteria using Rayyan (Ouzzani et al., 2016). Interrater reliability following this stage was 0.97, in which any disagreements (n = 366) were resolved through discussion with a third reviewer. To supplement the systematic search of these electronic databases, we also consulted two field experts to identify any studies that were not included. Finally, we undertook a manual search of journals publishing articles in the psychology of religion to ensure all relevant articles were found. The full text of the final sample of articles following title–abstract screening was reviewed for their suitability for this systematic review against our inclusion criteria.

Data Extraction and Quality Appraisal

We extracted themes from the final sample of articles along with demographic and study design information. This is included in Supplemental Table S3. The quality of the studies was reviewed using the Critical Appraisal Skills Programme (CASP, 2018). CASP comprises 10 questions used to assess the quality of qualitative studies. The first six questions relate to the validity of the results and assess the clarity of the research aim, the appropriateness of employing a qualitative methodology, the appropriateness of the research design, recruitment strategy, and data collection, and the consideration given to the relationship between the researchers and participants. Three questions address the results of the study,

assessing the consideration given to ethical issues, the rigor of the data analysis, and the clarity of statement of findings. The final question assesses the value and impact of the research. We answered each question on a scale of 1–10 and found the average score to classify articles into low (0–3), medium-low (3–5), medium (5–6.5), medium-high (6.5–7.5), and high (7.5–10) quality. All appraised articles with a score equal to a group boundary (i.e., 3, 5, 6.5, 7.5) were categorized into the lower quality grouping (e.g., 7.5 = medium-high). The quality of studies ranged from 5.2 to 9.1 in which the average quality rating across all papers was 7.2. As there is little evidence about decisions to exclude studies on the basis of their CASP appraisal rating (Thomas & Harden, 2008), all studies were considered to be of a high enough quality to be included.

Data Analysis and Synthesis

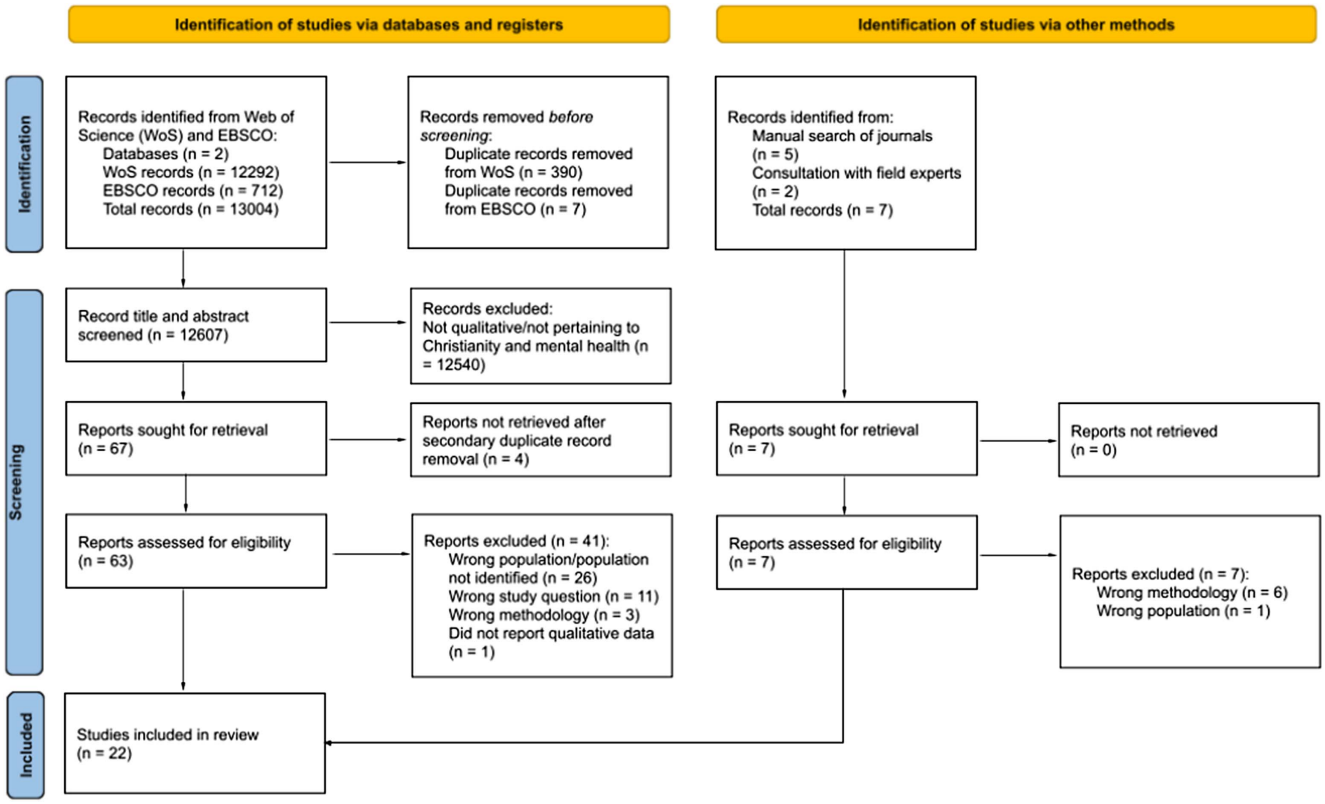
Extracted data from the included articles were integrated using the six stages of thematic analyses as outlined by Braun and Clarke (2006): We familiarized ourselves with the data during the full-text reviews, data extraction, and repeated reading of the data (Phase 1). Subsequently, we generated initial codes from the data (Phase 2) before the lead researcher began to group the codes into descriptive, candidate themes (Phase 3). The candidate themes were subsequently reviewed and refined by the full research team, with any edits or refinements of the themes being discussed to consensus (Phase 4). We defined and named our themes (Phase 5) before writing up the thematic analysis (Phase 6). In addition, we followed the guidance of Thomas and Harden (2008) in synthesizing qualitative data for conducting qualitative metasynthesis. They describe a three-step process that involves coding the data, developing *descriptive* themes, and refining them into *analytical* themes: The coding of data supported the translation of concepts between studies and began the process of synthesis by identifying similarities across the data (Phase 1). Descriptive themes are generated by the initial sorting of the codes. These candidate themes are so named because the initial themes developed during data synthesis describe (and integrate) the data of the synthesized studies without straying far from the studies' original findings (Phase 2). The descriptive themes are interpreted beyond the primary studies in order to potentially generate new interpretive constructs or explanations and to view the included studies as a whole and larger narrative. This process generates analytical themes (Phase 3). Thematic analysis was compatible with the process outlined by Thomas and Harden (2008). To address analytical rigor and thematic credibility, the researchers kept an audit trail and reflexive journals throughout the process.

Results

Study Selection

Of the 13,004 articles identified through our database search, 22 were included in the study. Figure 1 displays the results of the database search and screening process. A data extraction table for the

Figure 1
PRISMA



Note. PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses. See the online article for the color version of this figure.

synthesized studies is included in Supplemental Table S3. We appraised each article using the Critical Appraisal Skills Programme (CASP, 2018) guidelines and considered each to be of suitable quality for inclusion. The total sample of the 22 included studies was 897 participants, with sampling occurring across five countries: the United States ($n = 12$), the United Kingdom ($n = 6$), Australia ($n = 2$), Canada ($n = 1$), and Sweden ($n = 1$). A wide range of Christian groups and denominations were explored (Anglican, Baptist, Catholic, Charismatic, Evangelical, Jehovah's Witness, Methodist, Orthodox, Pentecostal, Presbyterian, Protestant, Seventh Day Adventist), with some participants belonging to more than one or not identifying with any specific denomination. The type and nature of mental illness among participants varied.

Results of Thematic Synthesis

The analysis of synthesized data sought to explore the experiences and perceptions of mental illness in the context of Christian church community and faith and resulted in the identification of four overarching themes and eight subthemes. Fifteen initial descriptive themes were developed by the lead researcher; these themes were reviewed by two additional researchers, and refinements of the themes were made until consensus. During the review, we recognized that all of the 15 initial themes pertained to four main areas in relation to the experience of mental illness (i.e., the positive/negative aspects of Christian communities and the positive/negative aspects of Christian faith and meaning systems). We included the candidate themes that were present across at least 50% of the synthesized studies to ensure the themes constituted patterns within the data. All four themes were included as they occurred across 50%–72.7% of the synthesized studies. We developed subthemes within these four broader categorizations through a process of grouping similar or repeated candidate themes and excluding candidate themes that lacked sufficient support in the data, such that each subtheme was distinct yet coherent in relation to its overarching theme (Braun & Clarke, 2006). We included the candidate subthemes that were present across seven or more of the synthesized studies and excluded the subthemes present across six or less of the synthesized studies. Therefore, all included subthemes occurred across approximately one third of the synthesized studies. These criteria allowed for the recognition of the diverse experiences of Christianity in relation to mental health yet ensured that all themes and subthemes were valid and constituted patterns within the data. The four overarching themes and eight subthemes are described, along with examples, in Table 1.

Description of Themes

In relation to the experiences of mental illness amongst Christians, the articles reviewed reported a number of positive experiences around Christianity and mental health. The positive aspects of faith and community were distinct in two areas, which comprised two master themes: *positive experiences of Christian communities* and *positive coping through Christian meaning systems*. In addition, the negative aspects of faith and community in relation to mental illness were collated into two master themes: *negative experiences of Christian communities* and *difficulties managing faith amid suffering*. These themes reflect the diversity of experiences and perceptions of mental illness within Christian communities and map how church communities can act to bolster mental health if congregations and religious leaders are felt to be supportive and accepting. Conversely, a judgmental and discriminatory Christian community has been found to hinder mental health. Similarly, whether one's faith acts as a positive or negative influence on the experience of mental illness appears to depend on whether mental illness is characterized as oppositional to, or as normative, and hence as part of one's religious and personal journey. Each of these master themes, along with their relevant subthemes, is outlined below.

Positive Experiences of Christian Communities

Congregational Support

The theme of *congregational support* describes the spiritual and mental support provided by church communities to Christians experiencing mental illness. This was a prominent theme, present across 12 of the synthesized articles. Church membership and engagement with congregational communities were presented as being spiritually and mentally restorative to participants with mental illness (Keefe et al., 2016; Tuffour, 2020; Virdee et al., 2016; Whitley, 2012; Wittink et al., 2009). The church acted as a space that provided vital congregational support. The participants described feeling welcomed and accepted in churches and religious spaces (Keefe et al., 2016; Lloyd et al., 2022; Whitley, 2012); they noted they were treated with respect and without judgment (Baker, 2010; Lloyd et al., 2022). Engagement in church and religious communities, participants reported, allowed for the development of meaningful and positive social relationships with congregation members who shared common interests and spiritual strivings (De Castella & Simmonds, 2013; Lloyd et al., 2022; Pivarunas, 2016). Some participants noted the social relationships they developed through their religious community were especially beneficial in the absence of strong, familial support networks (Baker, 2010; Wittink et al., 2009). The positive social bonds the participants made with congregation members offered opportunity for pastoral support. Congregation members reportedly offered practical help and advice (e.g., listening with care; Lloyd et al., 2022; Lloyd & Panagopoulos, 2022), as well as emotional support throughout the participants' experience of mental illness (De Castella & Simmonds, 2013; Lloyd et al., 2022; Lloyd & Hutchinson, 2022; Lloyd & Panagopoulos, 2022; Virdee et al., 2016). In addition to its social aspects, congregational support was described as providing vital spiritual support for the difficulties associated with mental illness. Participants noted that their social relationships with congregational members helped them grow spiritually and develop a deeper relationship with God (De Castella & Simmonds, 2013; Pivarunas, 2016). Moreover, congregational members reportedly offered spiritual support through prayer, facilitating close relationships between the participants and congregational members and offering healing in relation to the participants' mental illness (De Castella & Simmonds, 2013; Keefe et al., 2016; Lloyd & Panagopoulos, 2022; Oxhandler et al., 2018; Tuffour, 2020). The subtheme of congregational support highlights how the church space held the distinct ability to provide social and spiritual connection as well as support and healing for participants across the studies.

Faith Leaders and Pastoral Care

The subtheme of *faith leaders and pastoral care* was evident in seven studies and provided insight into the role of faith leaders in

Table 1
Theme Descriptions and Illustrative Quotes

Themes and subthemes	Descriptions	Illustrative quotes
Positive experiences of Christian communities	This master theme reflects the various ways in which people report experiencing positive interpersonal interactions with other Christians in relation to their mental illness.	
Congregational support	Church and religious community members are welcoming, accepting, and nonjudgmental; developing relationships with these members offers individuals with mental illness, social, emotional, and spiritual support.	"It was a relief to Tom to feel accepted, and to be considered a person, rather than to be treated as a problem to be solved" (Lloyd et al., 2022, p. 7). "Healing moments for me sometimes occur in interaction with other people. … I guess for me it's like having God with flesh on in a spiritual sense" (De Castella & Simmonds, 2013, p. 547). "being involved in prayer groups was particularly helpful because it gave me a safe community environment where I felt, I began to feel safe and was able to share my thoughts and feelings and feel surrounded by people that have the same sort of journey" (De Castella & Simmonds, 2013, p. 551).
Faith leaders and pastoral care	Faith leaders offer nonjudgmental emotional, social, and spiritual support to individuals experiencing mental illness.	"I used to go and see this minister, and just go and see him in the week day. He was almost like a father to me" (Baker, 2010, p. 243). "If you talk to like a pastor or somebody I don't think they would judge you" (Bryant et al., 2014, p. 267). "If you talk to your pastor … he always is more or less private and just knowing that you can talk with somebody who has had dealings with people like that or know that they aren't just telling you things just for making you think 'I can help you' but really help you" (Wittink et al., 2009, p. 405).
Positive coping through Christian meaning systems	This master theme captures the various positive experiences of one's faith and personal relationship with God in relation to mental illness, for example, finding purpose, praying, and sharing burdens with God.	
Religious meaning-making	Outlines the ways in which faith offers explanatory frameworks of mental illness, providing a sense of meaning to illness and suffering, developing a sense of purpose in the individual, and generating spiritual transformation.	"If God made you that way, then you're that way for a reason. God doesn't put you through anything you can't handle" (Oxhandler et al., 2018, p. 193). "My view of suffering has really become changed because there's a deeper, deeper level of meaning as to what suffering's all about. Like it's a real honour to suffer, in a way it's like being like our Christ" (De Castella & Simmonds, 2013, p. 544). "Now, after the incident I have a much, much deeper understanding of why I go to church to practice my religion. I understand what it means to go to church, what I receive from attending the mass. And what I gain from attending the mass and having all that understanding that brings me, that strengthens my spirituality, which means that I'm able to live my life daily in a new way, a new purpose and with so much more meaning" (De Castella & Simmonds, 2013, p. 547).
Positive coping through relationship with God	Outlines the positive or helpful responses to and means of coping with mental illness among Christians; namely, it explores supportive and meaningful relationships with God and religious practice, for example, prayer and *The Bible*-reading.	"I have an ongoing day-to-day, minute-by-minute relationship with God. So it's not something that happens in church on a Sunday morning, and that, that is really sustaining and supportive for me and comforting for me to have that kind of relationship" (De Castella & Simmonds, 2013, p. 548). "I think it's helping me because I'm able to rely on God. I'm able to rely on someone who can take care of me and make sure I don't get sick again, guiding me to the right path" (Tuffour, 2020, p. 357). "Prayer is a healer … there is healing in prayers" (Tuffour, 2020, p. 356). "I remember just crying out to God in pain and agony and needing Him. And I used to read through the psalms which are all about anguish, and anguish and crying out to God. And that actually, because I don't think I could put into words myself apart from just crying out 'just help me and heal me and make me whole, and help me to be myself again and to be confident and trust people'. So saying, going through those psalms really, really helped a lot" (De Castella & Simmonds, 2013, p. 544).

Themes and subthemes	Descriptions	Illustrative quotes
Negative experiences of Christian communities	This master theme explores the various ways in which people report experiencing negative interpersonal interactions with other Christians in relation to their mental illness.	
Imposed spiritualization of mental illness	Outlines the negative ways in which mental illness is framed through Christian contexts and communities; it explores the characterization of mental illness as a failure of faith or as demonic influence.	"There was always the impression given that you weren't a good enough Christian if you had depression, because to have Jesus in your life meant you shouldn't be depressed but joyful and thankful" (Lloyd & Hutchinson, 2022, p. 5). "I've never felt like I measured up as a Christian and I know that taps into a lot of stuff from the past" (Proctor et al., 2019, p. 101). "They prayed over you, and obviously nothing happened, and I thought, 'Well, that's because the demon is very stubborn'—this is what they tell you" (Baker, 2010, p. 244). "They would argue that Satan's having a go at me, but I don't think that" (Proctor et al., 2019, p. 101).
Stigma, exclusion, and marginalization	Outlines the social difficulties faced by Christians experiencing mental illness in intolerant Christian communities; specifically, it reflects exclusion, the hiding of symptoms, and departure from church communities.	"I think there were very few people in those churches who understood [mental distress]. If they did know something about it. They didn't have any way [of expressing it]. There was no language to talk about it in relation to faith. There was no framework for those conversations to take place" (Lloyd, 2021, p. 2713). "I was quite disappointed with the support I received from my previous church. I'm a singer and musician and was keen to be involved in the praise group as I felt God had given me talent that I should use for his glory. However, the worship leader kept being evasive about me joining. … The worship leader said she had been told by the leadership. … Because I wasn't well. With my depression they couldn't risk having me on the platform in front of our church in case I had a meltdown. I think it was an underhand and an unchristian way of dealing with me. If I'd had a broken leg, they wouldn't have denied me access to the praise team and the platform in case I broke my other leg. So why treat my brain any different?" (Lloyd & Hutchinson, 2022, p. 6). "He was scared that if he was honest about his difficulties people would avoid him and disregard him. He was embarrassed by his depression and kept it secret" (Lloyd et al., 2022, p. 6). "I was offered no support following my suicide attempt, so I've closed the door on church" (Lloyd & Hutchinson, 2022, p. 6).
Difficulties navigating faith amid suffering	This master theme captures the various negative experiences relating to one's faith and personal relationship with God in relation to mental illness, for example, questioning faith due to mental illness, feelings of failure as a Christian, and negative affect due to ongoing suffering.	
Dissonance: mental illness and faith	Doubting faith and the existence of God to intervene in, or remedy suffering due to ongoing mental illness.	"If there really is a God, why does God allow shit like this to happen?" (Sherman et al., 2018, p. 371). "How could God love me when my parents haven't had love for me, I must be a real stuffer, I'm just garbage" (Proctor et al., 2019, p. 96).
Negative affect	Experiences of negative affect due to dissonance between lived experience of mental illness and faith. This included feeling guilt and self-blame as a result of persisting experiences of mental illness.	"It was like I had myself to blame. That I was on the wrong track and God was that stern parent that would discipline me. I was to be disciplined. There was always an element of dissatisfaction. I was never fully sufficient" (Lilja et al., 2016, p. 5). "[She] feels a great deal of guilt about this and frequently confesses and asks for deliverance from it. She often wonders if she is possessed or has done something wrong" (Lloyd & Panagopoulos, 2022, p. 300).

ameliorating experiences of emotional distress and mental illness. Descriptions across the articles included leaders who were kind and welcoming, positioning faith leaders as approachable, discrete, and nonjudgmental supporters throughout the participants' experience of mental illness (Baker, 2010; Bryant et al., 2014; Lloyd & Panagopoulos, 2022; Whitley, 2012; Wittink et al., 2009). For some participants, faith leaders were described as having the experience to be effective in a support role for Christians experiencing mental illness (Wittink et al., 2009). Faith leaders were often described by the participants as providing spiritual support through prayer (Baker, 2010; Lloyd & Hutchinson, 2022), as well as offering spiritual guidance in relation to the experience of mental illness (Lloyd & Panagopoulos, 2022; Oxhandler et al., 2018; Whitley, 2012); this spiritual support reportedly gave feelings of relief and hopefulness regarding the participants' present suffering (Baker, 2010; Lloyd & Panagopoulos, 2022; Oxhandler et al., 2018). In addition to spiritual care, faith leaders were described as offering pastoral care that was accessible and practical (e.g., encouraging engagement in church, individualized support; Baker, 2010; Whitley, 2012). Across the articles, nonjudgmental faith leaders who provided pastoral and spiritual care were reported as holding a positive significance to those Christians with experiences of mental illness.

Positive Coping Through Christian Meaning Systems

Religious Meaning-Making

The theme of *religious meaning-making* describes the ways in which faith offers explanatory frameworks of mental illness across the articles. This theme was evident across seven articles. By conceptualizing their experience of mental illness within a religious framework, participants described their faith as facilitating a sense of meaning, purpose, and ability to cope with the associated difficulties of mental illness; these feelings reportedly stemmed from a recognition of God's plan for the participant (Holliman et al., 2018; Oxhandler et al., 2018; Starnino, 2016; Starnino & Canda, 2014; Tuffour, 2020). Participants who contextualized their mental illness and suffering in religious teaching and belief reported enhanced self-understanding (e.g., discovering oneself through adversity, developing one's understanding of Christianity), spiritual renewal (e.g., feeling stronger in faith and closer to God), and religious practice (e.g., increased prayer and church attendance; De Castella & Simmonds, 2013; Sherman et al., 2018; Starnino, 2016). Moreover, some participants were able to create meaning around their suffering, citing Christ's atonement as providing a biblical precedent for and sense of meaning to suffering (De Castella & Simmonds, 2013). The experience of suffering generated a sense of purpose among participants when framed by this aspect of the Christian faith, encouraging feelings of positivity, authenticity, and meaning (De Castella & Simmonds, 2013).

Positive Coping Through Relationship With God

The theme of *positive coping through relationship with God* was found across 16 of the 22 articles. These articles acknowledged that belief in a supportive God allowed for a positive means of coping with mental illness among Christians. A commonly reported belief was that God had a plan and purpose for each individual and would not subject them to difficulties that they could not overcome; this illustrates how participants used their relationship with God as a means to cope with the suffering associated with mental illness (Holliman et al., 2018; Lloyd & Hutchinson, 2022; Oxhandler et al., 2018; Sherman et al., 2018; Starnino, 2016; Starnino & Canda, 2014). Throughout the articles, the relationship with God was characterized as personal and comforting, where God is seen as an accessible and available social support and strength (De Castella & Simmonds, 2013; Lilja et al., 2016; Oxhandler et al., 2018).

Participants created meaning by describing feeling loved by, cared for, and important to God, which ultimately generated feelings of security, importance, and happiness (De Castella & Simmonds, 2013; Holliman et al., 2018; Whitley, 2012). The positive aspects of this relationship for the individual are further illustrated by reports of prayer as a means of connection to God, providing healing and support through the difficulties and suffering associated with mental illness (Holliman et al., 2018; Keefe et al., 2016; Tuffour, 2020; Wittink et al., 2009). The participants described the power of prayer to give relief and guidance when feeling desperate or overwhelmed due to their illness (Holliman et al., 2018; Keefe et al., 2016; Lloyd & Hutchinson, 2022; Oxhandler et al., 2018; Wittink et al., 2009). In addition to prayer, reading *The Bible* was considered a positive coping method across the articles as a means of contextualizing their suffering within biblical narratives (De Castella & Simmonds, 2013; Holliman et al., 2018; Lloyd, 2021).

Noting the benefits of having a positive relationship with God, the participants described being able to ease their suffering by sharing the burdens associated with mental illness with God (Keefe et al., 2016; Lloyd et al., 2022; Sherman et al., 2018; Whitley, 2012). The participants referred to God's power and plan, such that they could feel secure in the knowledge that God is in control, even throughout their suffering (Holliman et al., 2018; Whitley, 2012). This reliance on God and submission to God's plan provided the participants with feelings of calmness, strength, and protection and was an especially prominent sentiment across the synthesized papers (De Castella & Simmonds, 2013; Holliman et al., 2018; Keefe et al., 2016; Lilja et al., 2016; Lloyd et al., 2022; Lloyd & Hutchinson, 2022; Pivarunas, 2016; Proctor et al., 2019; Sherman et al., 2018; Tuffour, 2020; Whitley, 2012; Wittink et al., 2009). Though some participants stated their reliance on God removed any worry or distress associated with their illness (Lloyd & Hutchinson, 2022; Tuffour, 2020; Wittink et al., 2009), it was more widely reported that God provided the participants support throughout the illness and inspired hope that their circumstances would improve (Keefe et al., 2016; Lloyd et al., 2022; Proctor et al., 2019; Tuffour, 2020; Whitley, 2012).

Negative Experience of Christian Communities

Imposed Spiritualization of Mental Illness

The theme of *imposed spiritualization of mental illness* describes the negative ways in which mental illness is framed through Christian contexts and communities; specifically, it explores how the characterization of mental illness as a failure of faith, or as demonic influence, can negatively impact Christians experiencing mental illness. Reference to this theme occurred across nine of the 22 articles.

Participants referenced the experience of being told, or made to feel, that one's mental illness is directly related to a failure in their

faith. They described their experiences of being made to feel inadequate in their faith and ostracized in their churches due to their mental distress (Lloyd & Hutchinson, 2022; Proctor et al., 2019). It was noted that these experiences stemmed from congregational judgment of the participants' inability to be healed through faith and, by extension, their assumed failure of the participants' faith (Lloyd et al., 2022). Participants reported that Christian communities may characterize mental illness as being caused by individual failures of the participants, such as insufficient prayer and *The Bible*-reading, a lack of faith, or an inadequate relationship with God (Lloyd, 2021; Lloyd et al., 2022). When seeking to address these purported insufficiencies by attempting to trust God, pray, and read *The Bible* more, participants reported increased distress in instances where healing through religious belief and practice did not occur. This was reported as leading to further feelings of disconnection from the church community and failure as a Christian (Lloyd, 2021; Lloyd et al., 2022). In addition, participants reported that spiritualized mental health support from congregational members encouraging increased faith was unclear and impractical; this advice offered little support to individuals experiencing mental illness and worked to confuse, reinforce notions of inadequacy, and isolate participants (Lloyd et al., 2022). Participants described the negative ways in which this spiritualization of mental illness could be internalized, generating feelings of shame (Lloyd & Panagopoulos, 2022), guilt, and anxiety (Lloyd et al., 2022), and emphasizing the perceived disparity between the experience of mental illness and the perception of what it means to be a good Christian (Lloyd & Hutchinson, 2022). The emphasis on spiritual inadequacies as being heavily influential in mental illness made some participants disinclined to voice their struggles or access therapeutic care (Lloyd & Panagopoulos, 2022).

In addition, the participants outlined how experiences of mental illness among Christians may be explained by church communities with reference to demonic possession, influence, and attack. They noted that church communities may reject naturalistic etiological explanations for mental illness, instead citing spiritual attacks by the demonic (Baker, 2010). Participants described being told directly by Christian members that they were not mentally ill but instead influenced by demons (Baker, 2010; Lloyd & Hutchinson, 2022), denying or overriding the participants' own beliefs regarding the authenticity of their mental illness and causing distress (Lloyd, 2021; Lloyd & Hutchinson, 2022; Proctor et al., 2019). In this demonic framework of spiritualized mental distress, participants noted, church leaders and members could accuse individuals experiencing mental illness of engaging with demons and the occult (Baker, 2010), ascribing an individual failure of faith on the part of the participants. In turn, the participants described feelings of judgment from the church community, often being made to feel inadequate, isolated, and othered (Baker, 2010; Lloyd, 2021). The deliverance therapies and exorcisms experienced by the participants were reportedly ineffective and distressing (Baker, 2010; Lloyd, 2021). Furthermore, participants noted that the rejection of mental illness in lieu of demonic influence acts as a barrier for Christians experiencing mental illness to access mental health services. Spiritualizing mental illness as an issue of demonic influence reportedly discouraged Christians from seeking mental health support, as suffering and distress were considered solely spiritual rather than psychosocial terms (Coombs et al., 2022). This spiritualization of mental health led church leaders and members to prohibit some participants from accessing mental health services (Lloyd & Hutchinson, 2022). In some instances, however, the characterization of mental illness as demonic (Lilja et al., 2016; Whitley, 2012) and the involvement in demon-targeted therapies (Baker, 2010; Lloyd & Panagopoulos, 2022) may aid Christians' coping with mental illness.

Stigma, Exclusion, and Marginalization

The theme of *stigma, exclusion, and marginalization* characterizes the social difficulties faced by Christians experiencing mental illness in intolerant Christian communities. These negative social interactions can cause Christians experiencing mental illness to feel excluded, hide their symptoms for fear of judgment, and leave the church community. It was present across 10 of the 22 articles.

Participants noted that congregational members did not fully understand the struggles associated with mental illness (Caplan, 2019; Lloyd, 2021; Proctor et al., 2019) due to a lack of mental health awareness and literacy in church settings (Coombs et al., 2022; Lloyd, 2021). This lack of mental health awareness, the participants reported, led to the mistreatment and stigmatization of Christians experiencing mental illness. Several participants experienced dismissive social interactions with church community members, with some members disregarding the authenticity of the participants' mental illness (Caplan, 2019; Lloyd et al., 2022; Virdee et al., 2016). It was reportedly common for the participants to be considered problematic or difficult members of the church community due to the needs and struggles associated with their mental illness (Baker, 2010; Caplan, 2019; Lloyd et al., 2022; Lloyd & Hutchinson, 2022; Lloyd & Panagopoulos, 2022; Proctor et al., 2019). In turn, the participants described facing judgment from, being shamed by, and being abandoned by their church community due to their mental illness (Baker, 2010; Lloyd, 2021; Lloyd & Panagopoulos, 2022; Proctor et al., 2019). The participants noted that these negative social interactions stemming from the stigmatization of mental illness marginalized and isolated Christians experiencing mental illness (De Castella & Simmonds, 2013; Lloyd et al., 2022; Lloyd & Hutchinson, 2022; Proctor et al., 2019). Specifically, some participants described physically isolating themselves while in the church space due to fear of discrimination (Proctor et al., 2019), whereas others were excluded by church community members from church activities because of their mental illness, causing distress among participants (Lloyd et al., 2022; Lloyd & Hutchinson, 2022).

As a means of coping with the stigmatization of mental illness, participants described the perceived need to hide their symptoms of mental illness from church members due to fear of judgment. They reported their disinclination to be honest about their health struggles due to fear of stigma and rejection from the church community (Baker, 2010; Lloyd et al., 2022; Proctor et al., 2019). This stigmatization of mental illness pressured some participants to effortfully present a persona that masks their illness in the hope of avoiding judgment (Baker, 2010; Lloyd & Panagopoulos, 2022; Proctor et al., 2019). In addition, the stigmatization and isolation of some participants reportedly made church an untenably distressing social environment in which relief could only be achieved by leaving the church community (Lloyd et al., 2022; Lloyd & Hutchinson, 2022; Proctor et al., 2019).

Difficulties Navigating Faith Amid Suffering

Dissonance: Mental Illness and Faith

The theme of *dissonance: mental illness and faith* outlines participants' doubts in relation to their faith and the existence of God to intervene in, or remedy, suffering due to ongoing mental illness. Present in eight of the synthesized articles, the theme explores the dissonant relationship between faith and mental illness.

The often chronic experience of mental illness presented many challenges to the health of participants in relation to their Christian faith, as participants attempted to navigate the gap between their church teaching and beliefs regarding mental illness and their continued experiences of illness despite this. In these instances, mental illness was framed by the participants as the result of a loss or questioning of faith, positioning mental illness and faith as conflicting, discordant, but connected concepts (De Castella & Simmonds, 2013; Proctor et al., 2019; Sherman et al., 2018; Wittink et al., 2009). Furthermore, the suffering experienced by participants during their illness generated various dissonant relationships between their mental illness and faith. The participants reported that their experience of suffering and illness made them doubt the righteousness and morality of God, leading some to question the existence of God (De Castella & Simmonds, 2013; Sherman et al., 2018). Other participants described how their mental illness caused them to doubt their adequacy as a Christian (Lilja et al., 2016; Lloyd & Hutchinson, 2022; Lloyd & Panagopoulos, 2022) and deservedness of God's love (Lloyd & Hutchinson, 2022; Proctor et al., 2019; Starnino, 2016). In some cases, mental illness was described as a punishment for sinful behavior or deviations from Christianity (Lilja et al., 2016; Starnino, 2016).

Negative Affect

This theme describes the experiences of negative affect due to the dissonance between the lived experience of mental illness and faith; specifically, it explores the dejection, guilt, and self-blame generated through this dissonance. *Negative affect* was reported across eight of the synthesized articles.

In developing a link between mental illness and doubts or failures of faith, the participants described feeling inadequate as Christians and resulted in participants internalizing feelings of guilt and self-blame (Lilja et al., 2016; Lloyd & Hutchinson, 2022; Lloyd & Panagopoulos, 2022). Some participants noted that the experience of mental illness made it physically and spiritually difficult to communicate with God or seek relief through prayer, leaving them dejected (Proctor et al., 2019; Tuffour, 2020). Similarly, participants described that being unable to meet the standards or perform the duties associated with being a Christian, such as reading *The Bible* or praying for others, caused feelings of dejection and distress (Lilja et al., 2016; Lloyd & Hutchinson, 2022; Lloyd & Panagopoulos, 2022; Proctor et al., 2019). In relation to the characterization of mental illness as a failure of faith, some participants reported feeling guilty about their inability to recover through their faith; in turn, they were disinclined to pursue therapeutic support or medication as it implied a failure of faith on their part (Baker, 2010; Caplan, 2019; Lloyd & Hutchinson, 2022).

Discussion

This is the first qualitative metasynthesis to systematically collate studies that have explored how Christians with lived experience of mental illness perceive the role of their faith and wider church community. Our qualitative metasynthesis identified 22 eligible studies, which were subject to the Critical Appraisal Skills Programme (CASP, 2018) assessment, data extraction, and analysis. This diverges from Milner et al. (2020), who previously undertook a qualitative systematic review focusing on the experiences of spirituality and mental illness and instead used the strengths of this methodological approach to focus on a Christian population. This is meaningful as monotheistic and other religious and spiritual groups cannot be assumed to have homogenous beliefs or practices (Koenig, 2012).

We identified four themes higher level themes with their related subthemes, which characterized experiences of Christian faith and community among people with mental illness. One theme, positive experiences of Christian communities, involved subthemes of congregational support and faith leaders and pastoral care. Another theme, positive coping through Christian Meaning Systems, involved subthemes of religious meaning-making and positive coping through relationship with *God*. A third theme, negative experiences of Christian communities, involved subthemes of imposed spiritualization of mental illness and stigma, exclusion, and marginalization. A fourth theme, difficulties navigating faith amid suffering, involved subthemes of dissonance: mental illness and faith and negative affect. Our findings, explored via the detailed collation and examination of subjective experience, meaning-making and context (Coyle, 2008; Lloyd, 2023b), are significant as they document the specific conditions under which Christianity may be experienced as both a support and as a hindrance for those living with mental illness. This is notable given the growing attention to matters of mental illness within the Christian tradition (Cook & Hamley, 2020). To date, there have been mixed findings from qualitative studies regarding the relationship between Christian faith and community for those living with mental illness. Below, we summarize our findings before discussing these in relation to existing theory and literature.

Our findings illuminate the nuance and specificity of Christian religious belief and practice and their relative impact on mental illness across cultures. In summary, we found that Christianity has the potential to facilitate positive religious coping with mental illness. Specifically, congregational belonging may support positive religious coping when delivered via nonjudgemental pastoral care and wider forms of social support. In addition, specific religious practices, such as reading *The Bible* and prayer may also facilitate positive religious coping with mental illness, when framed as additional tools that allow the individual to draw closer to God and to contextualize, accept, and address mental illness. Finally, belief in God as a positive and supportive agent was also identified as beneficial in coping with mental illness. In juxtaposition, however, Christian religious belief and practice have potential to contribute to negative religious coping when congregations perceive mental illness through a solely spiritualized lens, viewing it as a failure of faith or the result of demonic possession. Within our review, we found that such perceptions often led to negative affect through self-blame and increased cognitive dissonance between faith and experiences of mental illness. Of particular significance across our review of the collated studies was deeper insight into the mechanisms and contexts

that might lead to negative views of self and others. Specifically, the spiritualization of mental illness was found to promote positive meaning for individuals if incorporated into an individual's wider belief and meaning systems. However, if the spiritualization of mental illness was imposed by a wider faith community, it could encourage the characterization of a stigmatized identity (e.g., "you're demonic"), which may promote self-stigma, prevent relational connection, and even generate mental illness. We now turn to address these findings in relation to existing theory and literature.

First, our analyses showed that Christians perceive their church communities to provide substantial benefits to their mental health, namely by strengthening faith, improving social connection, and offering sanctuary. Faith leaders were also identified as significant in offering nonjudgmental emotional and relational support during periods of emotional distress. These findings mirror and corroborate existing theoretical literature that discusses the importance of religious communities in offering social support, or, in other words, the emotional and tangible support that one receives, provides, and expects from one's religious community (Barrett, 2013). Thus, the present study documents this as a significant feature identified in existing qualitative research in this area.

Second, meaning-making as a positive element of personal faith was identified. Here, participants discussed the pivotal role of their faith in providing explanatory models and meaning, which were often reported as helpful in coping with mental illness. Examples included viewing mental illness as normative due to biblical portrayals of suffering and belief in prayer and biblical study as adaptive. These findings are not necessarily surprising given the sizeable literature on positive religious coping and the ways in which religious belief systems may imbue meaning during difficult life experiences (e.g., Lomax et al., 2016; Pargament & Raiya, 2007) and allow for positive coping through adversity (Park, 2005); however, these findings are significant considering there has been notably less investigation around meaning-making from a psychiatric perspective despite the importance it has for people with mental illness (Huguelet, 2017). Moreover, it may offer support to the work of Wilt et al. (2023), who found that causational attributions of daily events to supernatural agents increased the participants' sense of meaning; our findings emphasized the importance of attributions of the difficulties associated with mental illness to God and God's plan (Holliman et al., 2018; Oxhandler et al., 2018; Starnino, 2016; Starnino & Canda, 2014; Tuffour, 2020). In addition, our review found that having a positive relationship with God can aid and support Christians with mental illness, mapping onto theories of divine attachment. Grounded in attachment theory (Ainsworth & Bowlby, 1991), divine attachment theory conceptualizes the individual's personal relationship with God as a form of attachment (Kirkpatrick & Shaver, 1990; Rowatt & Kirkpatrick, 2002). In line with our findings, secure attachment with God among Christians has been found to be a positive support to mental well-being (Bradshaw et al., 2010; Ellison et al., 2012; Kirkpatrick et al., 1999; Lloyd & Reid, 2022).

In contrast to the positive experiences of the religious community and faith in coping with mental illness, there were also several negative aspects identified across the studies. In our review, we identified negative aspects as including those parts of the Christian tradition, teaching, or community that minimized the meaning systems of participants and led to stigma, isolation, a weakening of faith, and negative affect. It was notable that the spiritualization of mental illness could carry both a positive and negative influence for participants, often assuming a localized moral, personal, and theological significance. This is a noteworthy finding and one that requires further research, both qualitative and quantitative, to explore the conditions under which the spiritualization of mental illness may be both helpful or harmful for well-being. We found that the spiritualization of mental illness was often experienced as negative when this was not aligned with the individual's own meaning-making or context, supporting Lloyd's (2021) description of the spiritual reductionism that can occur in Christian settings. Regarding the positive experiences of the spiritualization of mental illness, it is possible that Christians experiencing mental illness who externalize the perceived influence of the demonic can benefit from a sense of individual agency and strength (Lloyd & Panagopoulos, 2023). Similarly, attributions of negative events to demons or the devil among individuals with a strong religious worldview can produce greater sense of meaning (Wilt et al., 2023). It is important to note that we found that positive experiences of spiritualized mental health can occur when the spiritualization of mental illness aligns with the individual's own belief system and is unlikely to occur in instances of imposed spiritualization.

While many participants held a positive view of God, their negative experiences of religious community and faith led to internal pressures and cognitive dissonance due to their experiences being divergent from their meaning system. In theoretical terms, when cognitive dissonance is experienced in relation to faith and religious meaning systems, cognitive discomfort and pressure on the meaning system may often result (Paloutzian, 2005). Individuals often strive to reduce this discomfort through continued meaning-making (Park, 2005). Negative experiences of religious communities and faith were frequently characterized by imposed or forced spiritualization of mental illness, which conflated mental illness as exclusively tantamount to sin, demons, or lack of personal faith.

These findings corroborate theories of spiritual abuse, which have noted that the mistreatment of an individual in need within a religious context can occur when the individual's opinions or beliefs are overridden or controlled by religious authorities (Johnson & VanVonderen, 1991; Oakley & Humphreys, 2019). Our review suggests that vulnerable Christians with mental illness may struggle to address and overcome spiritual abuse and imposed spiritualized accounts of mental illness. The negative social, spiritual, and emotional repercussions associated with spiritual abuse (Fernández, 2022) must also be faced in the context of the individual being demonized, shamed, and disconnected from a religious community that, in nonabusive contexts, may have offered emotional and spiritual support, as well as feelings of belonging and purpose. Moreover, as Scrutton (2020) acknowledges, these abusive or imposed theological belief systems can function problematically to divert attention away from social, economic, and political drivers of mental illness and to place excessive responsibility for illness on the individual. This is reflected in our findings that religious communities that promote spiritualized accounts of mental illness may discourage help-seeking outside of religious resources and frameworks (Coombs et al., 2022; Lloyd & Hutchinson, 2022). Simultaneously, it was reported in the studies that solely spiritualized belief systems were felt to contribute to stigma and social ostracization (Goffman, 1963; Link & Phelan, 2001). In our review, it was particularly significant that if church communities promoted a solely spiritual view of mental illness, there was increased risk of

stigmatized identities. While our findings are not surprising given the wealth of literature now demonstrating the more negative aspects of Christian faith for those living with mental illness, their repeated prominence across the collated studies is important.

Finally, the dissonance between theological teaching and belief regarding mental illness, alongside ongoing experiences of mental illness was identified as both a point of tension and iterative navigation by participants in the included studies. The experiences included participants' raising doubts in relation to their faith and the existence of God to intervene in, or remedy, suffering due to ongoing mental illness. It was identified in this review that this dissonance may lead to a questioning of faith and eventual negative affect, including experiences of self-blame, guilt, and worthlessness due to ongoing illness. These findings mirror the literature that explores negative religious coping and mental illness (Lucchetti et al., 2021). Negative religious coping (e.g., doubting or feeling abandoned by God; Hebert et al., 2009; Ramirez et al., 2012) and religious struggles (Fitchett et al., 2004; Magyar-Russell et al., 2014) have been associated with negative mental well-being among individuals with physical illnesses. Notably, our study describes the context in which mental illness may induce negative religious coping, such that the dissonance between church teaching and experience of suffering associated with mental illness can encourage doubts as to both God's ability to intervene as well as the individual's adequacy as a Christian. As this review noted that religious communities may be subject to poor mental health literacy and understanding of mental illness (Caplan, 2019; Coombs et al., 2022; Lloyd, 2021, 2023a; Proctor et al., 2019), it would be beneficial for future research to investigate the specific variables that contribute to experiencing dissonance in relation to one's religious teaching or religious support and illness. Preliminary work in this area suggests the importance of increasing church leader and community knowledge on mental health, promoting the inclusion of Christians with mental illness, and encouraging the integration of spiritual and biopsychosocial frameworks of mental illness (Lloyd, 2023a).

Study Strengths and Limitations

This is the first qualitative metasynthesis to focus solely on Christians' experiences of mental illness in relation to their faith and church community. By systematically collating and analyzing these studies, we have been able to create a single resource that provides synthesized findings exploring how Christians with mental illness experience their faith and community. This synthesis is particularly important as it draws upon a wide range of geographical locations (the United States, Canada, Sweden, the United Kingdom, and Australia), mental illnesses (eating disorders, stress, depression, dissociative identity disorder, posttraumatic stress, suicidal ideation, postpartum depression, bipolar disorder, drug abuse, panic disorder, generalized anxiety disorder, attention deficit hyperactivity disorder, psychosis, schizophrenia, and personality disorders) and qualitative designs (semistructured interviews, structured interviews, unstructured interviews, online qualitative surveys, focus groups, single case study designs, recorded therapy sessions, and the story completion method). In addition, varied methods of analyses are used (interpretative phenomenological analysis, thematic analysis, secondary data analysis, constant comparative analysis, systematic text condensation, hermeneutic phenomenological approach, and grounded theory—more information on each study may be found in Supplemental Table S3. Concurrent themes relating to experiences of mental health and faith communities were evident across the articles, with no significant differences in the presence of themes across locations or methods of data collection and analysis, illustrating the strength of findings across such diverse qualitative samples, methods, and analyses.

It is widely acknowledged, however, that the Christian tradition is diverse and varies depending upon denomination and tradition (Handman & Opas, 2019; Lloyd, 2023a). Accordingly, it would be useful for further qualitative reviews to focus on particular Christian traditions, such as Pentecostal or Catholic traditions, as examples, which have large areas of heterogeneity in terms of theology, infrastructure, belief systems, and practice.

In addition, while qualitative metasyntheses are invaluable in bringing together research evidence to help inform our practice and help us understand what works, they have also been subject to criticism. Specifically, qualitative metasyntheses may lead to decontextualized findings that are separated from the social and often localized context of the original studies. In trying to address this issue in the present review, we followed Thomas and Harden's (2008) suggestions for reporting study context. Notably, this included providing structured summaries of research contexts from the included studies, which are reported in Supplemental Table S3. Moreover, while our review was broad in scope and targeted several academic search engines, our review may have failed to identify measures published outside of the English language or in non-peer-reviewed publications.

Finally, following good practice guidance for the reporting of qualitative studies (American Psychological Association, 2020), we provide reflexive biographies for all authors in an attempt to improve transparency regarding author subjectivity, background, and motivation for conducting this review. A key strength of this review is that it documents and draws together existing empirical evidence regarding experiences of mental illness and faith amongst Christian groups in a way that is hard to capture with small-scale qualitative studies. In addition, the study spans a range of countries, cultures, Christian denominations, and mental health diagnoses, thus providing a diversity of contexts that contribute to the transferability and rigor of the findings.

Conclusions and Future Developments

This review offers a comprehensive resource for academics and clinicians who are interested in understanding how Christian faith and community may impact the experiences of those living with mental illness. By systematically mapping these experiences across published academic literature, this review provides new potential for improving care in these communities.

In our review, we have identified specific positive and negative aspects of the Christian faith in the lives of those living with mental illness. Four key themes were derived from the collated studies, which document the landscape of current research in this area. As qualitative research is useful for exploring subjective experiences and meaning in an inductive manner, it would be beneficial for future quantitative research to use hypotheticodeductive methodologies to quantify variables of interest generated through our qualitative metasynthesis. Specifically, quantitative research may investigate predictors of psychological well-being among Christian populations and create valid and reliable psychometric instruments

that measure variables of interest in sensitive and culturally syntonic terms. Significant examples that have been identified as important in the current metasynthesis include levels of social support from religious community and God, religious leaders attitudes to mental illness, beliefs around mental illness etiologies, and perceived God support. Furthermore, future research may helpfully focus on specific Christian denominations, which adhere to more homogenous belief systems. It would also be beneficial for future studies to explore mental illness within particular denominations that are known to espouse more extreme or rigid beliefs regarding spiritual etiologies for mental illness, such as those maintained by evangelical and charismatic denominations (Lloyd, 2021). Finally, future research may begin to shed light on what might be helpful or remedial when mental illness and Christian faith coalesce and the practical outworking of these in the lives of those who maintain Christian faith.

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Received February 9, 2023
Revision received September 15, 2023
Accepted September 15, 2023 ■