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RESEARCH ARTICLE

Acknowledging religion in cognitive behavioural therapy: The effect on alliance, treatment expectations and credibility in a video-vignette study

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Abstract

Objectives: Developing mental health services which are accessible and acceptable to those from minority backgrounds continues to be a priority. In the United Kingdom, individuals who identify with a religion are underrepresented in Talking Therapies services as compared to those with no religion. This necessitates an understanding of how therapy is perceived. This online study explored the impact of explicitly acknowledging religion on anticipated alliance, treatment credibility and expectations of therapy in a non-clinical sample of British Muslims.

Methods: A video-vignette experimental design was used in which participants who self-reported as either high or low in religiosity were randomly allocated to receiving information about cognitive behavioural therapy either with or without an explicit mention of religion as a value in the therapeutic process.

Results: One hundred twenty-nine British Muslim adults aged 18–70+ years from various ethnic backgrounds participated in the study. Between-subjects ANOVAs showed that scores on the perceived credibility of therapy and treatment expectations were significantly higher when religion was explicitly mentioned by the 'therapist', but that acknowledging religion did not impact upon anticipated alliance.

Conclusions: These findings suggest that mentioning religion as a value to be considered in therapy has some positive impacts upon how therapy is perceived by British Muslims. Although video vignettes do not provide insight into the complexity of actual therapeutic encounters, acknowledging religion in mental health services more broadly remains an

important consideration for improving equity of access and may bear relevance to other minoritized groups.

KEYWORDS
CBT, credibility, expectancy, Muslim, therapeutic alliance, therapy

Practitioner points

- When religion is important to clients, clinicians should explicitly state that they are open to discussing and incorporating religion into treatment.
- Acknowledging religion at the start of treatment may improve perceived credibility of therapy and treatment expectations for British Muslims.

INTRODUCTION

Over the last decade, there has been an increased focus on access to psychological services for minority groups (Hussain et al., 2022; Lawton et al., 2021; Loewenthal et al., 2012). In the United Kingdom, not only are racial and ethnic minority groups less likely to self-refer to National Health Service (NHS) Talking Therapies services, but when referred, are less likely than White British groups to receive an assessment and subsequent treatment (Harwood et al., 2021). Data on sociodemographic differences in the use of NHS Talking Therapies services finds that individuals with a religion are underrepresented as compared to those with no religion (Office for National Statistics, 2022), suggesting that those from religious backgrounds may be further marginalized in their access to mental health treatment.

Perceptions of therapy and how this may interact with faith identity are important when understanding engagement with mental health services; if secular services are perceived as not accommodating religious needs, religious individuals may choose not to or feel unable to engage with them. Religious clients report feeling that their spiritual needs are not accommodated in treatment (Mir & Sheikh, 2010), and hold fears that clinicians may minimize, misinterpret or even pathologize their religious beliefs (Byrne et al., 2017; Islam et al., 2015; Mayers et al., 2007; Naeem et al., 2010). These fears may contribute to *treatment expectations*, the beliefs clients hold about therapy, and in particular, how likely they are to benefit from treatment. Treatment expectation may be closely linked with *treatment credibility*, which is how believable, convincing and logical the treatment is (Constantino et al., 2011; Devilly & Borkovec, 2000). Credibility and outcome expectation are positively correlated in general samples (Ametrano et al., 2017; Constantino et al., 2014), and they each explain a unique portion of variance in patient outcomes (Mooney et al., 2014; Smeets et al., 2008), suggesting they are distinct factors and that they play a significant role in determining clinical change.

A third factor linked closely with treatment credibility and treatment expectation is the *therapeutic alliance*, which is the collaborative relationship developed between therapist and patient through the course of therapy (Bordin, 1979). The therapeutic alliance can be seen as having three distinct aspects: the 'goals' of therapy that the client and therapist agree upon, the 'tasks' by which these goals are obtained, and the 'bond' or relationship built between client and therapist (Bordin, 1994). If clients do not agree with the goals and tasks of therapy or believe that the therapist does not understand their problem in the same way as them, they may perceive treatment as not credible and inadequate for their needs and may have lower outcome expectations (D'Aniello et al., 2019).

Research exploring the development of the therapeutic alliance draws on social psychology literature suggesting that people tend to identify with individuals who are perceived as similar to themselves (Wintersteen et al., 2005). In therapy, perceived similarity may contribute to the development of greater initial trust based on a shared identity (Thompson et al., 2004; Wong et al., 2003). Where there are differences between therapist and client in valued domains, such as in the context of religious clients and non-religious therapists, it may be important to attend explicitly to this difference by acknowledging the client's religious beliefs, especially if the client views religion as a strong influence in their life.

There may be benefits to therapists indicating an openness to discussing religion and spirituality in treatment even when clients are unaware of the therapist's religious identity. For example, in an American study of majority Christian participants, Shumway and Waldo (2012) found that more religious participants predicted higher alliance in response to an invitation to address religious issues in counselling via a written consent form, despite not knowing the counsellor's religious identity. Additionally, Terepka and Hatfield (2020) found in their non-clinical sample that participants who engaged in a hypothetical psychotherapy intake session viewed interviewers who asked about religion as more empathetic, understanding, experienced and trustworthy and that more religious participants reported an increased willingness to disclose personal information when religion was enquired about. Such research supports the idea that incorporating religious beliefs into therapy may contribute to the development of strong alliances in secular settings.

The present study therefore aimed to gain an understanding of whether explicitly addressing religious values improves expected therapeutic alliance, perceived credibility and expectation of treatment, and whether this is impacted by level of religiosity. Given findings that British Muslims have poorer treatment outcomes than service users from other religious backgrounds (Baker, 2020; Mir et al., 2019), this study aimed to evaluate the impact of acknowledging religion on how therapy is perceived for this group. Qualitative studies suggest that British Muslims express a desire for religion to be incorporated into treatment (Ayub & Macaulay, 2023; Weatherhead & Daiches, 2010), however, there remains a dearth of literature on Muslims' perceptions of secular therapy services. Addressing this barrier for British Muslims may bear relevance on how other marginalized groups perceive and subsequently engage with mental health services and may also inform how we tailor interventions for clients of varying religiosity globally.

The present study therefore proposed the following research questions:

1. Does acknowledging the importance of religion as a specific value improve expected alliance, perception of treatment credibility and expectation of outcome with the therapist for British Muslim participants?
2. Are the above effects associated with the extent to which individuals self-identify as religious?

It was hypothesized that acknowledging religion as a value for Muslim participants would improve their expectations of therapy in terms of anticipated alliance with a White British therapist seen in a video vignette, as well as treatment credibility, and treatment expectation. It was hypothesized that these effects would be associated with level of religiosity in that participants with a higher level of religiosity would show a greater increase in alliance, credibility and overall treatment expectation.

METHOD

Design

A randomized experimental design was used to test the study hypotheses. Stratified randomization was used based on levels of religiosity (high vs. low) to one of two conditions: control condition (a video which referred to respecting values in general) and an experimental condition (a video in which religion was explicitly acknowledged).

Participants

Inclusion criteria were being over the age of 18 and identifying as British Muslim. Exclusion criteria were current or past experience of psychological therapy or having professional knowledge of Cognitive Behavioural Therapy (CBT). The exclusion criteria were chosen due to their potential influence on participants' perception of therapy, for example previous successful or unsuccessful attempts at integrating faith-based beliefs into therapy. The study was approved by the University of Oxford's Central University Research Ethics Committee (MRA-19/20–19878).

Participants were recruited between June and August 2022. Advertisements were shared on social media (WhatsApp, LinkedIn and Twitter) as well as by relevant networks such as the Muslim Researcher's Network and the British Islamic Medical Association. Participants who clicked on the link were taken to an information sheet and asked to give consent in line with inclusion and exclusion criteria. If they did not consent, they did not proceed with the study. All responses were anonymous.

Sample size

An a priori power analysis was conducted using G*Power3 (Faul et al., 2007) based on the primary dependent variable: expected alliance. A medium effect size ($d = .50$), and an alpha of .05 were specified, indicating that 128 participants were required to achieve a power of .80.

Measures

The study measures were self-report questionnaires characterizing the groups alongside the hypothesis testing variables, which were the Centrality of Religiosity Scale, the Working Alliance Inventory-Short Revised and the Credibility/Expectancy Questionnaire.

Grouping variable

Religiosity

The Centrality of Religiosity Scale (CRS; Huber & Huber, 2012) is a 15-item Likert-scale questionnaire which measures five core dimensions of religiosity: public practice, private practice, religious experience, ideology and the intellectual. The CRS has been validated for Muslim populations, for whom specific modifications were suggested and applied to this study (see Huber et al., 2020). Cronbach's alpha for this measure was .85 in the present sample.

Outcome variables

Expected Therapeutic Alliance

The *Working Alliance Inventory-Short Revised* (WAI-SR; Hatcher & Gillaspy, 2006; Horvath & Greenberg, 1989) is a 12-item measure of the strength of the therapeutic alliance and its three components; goals, tasks and bond. The WAI-SR has been adapted in previous studies by changing past and present verbs to the future tense so that it relates to expected alliance (See Nordgren et al., 2013; Shumway & Waldo, 2012). Cronbach's alpha for this measure was .95 in the present sample.

Credibility and Expectancy

The *Credibility/Expectancy Questionnaire* (CEQ; Devilly & Borkovec, 2000) is a 6-item questionnaire which measures treatment credibility and expectation of outcome. It explores how logical and useful the client

believes treatment to be as well as the improvement that the client thinks will occur. The measure uses two rating scales, one from 1 to 9 and another from 0% to 100%. In line with recommendations by Devilly and Borkovec (2000), each item was standardized for the present analysis. Good test–retest reliability has previously been established for the CEQ (Devilly & Borkovec, 2000).

Clinical and demographic characteristics

Participants provided their age, gender, ethnicity and religious sect.

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) is a 14-item scale with seven items measuring depression and seven measuring anxiety. The HADS was used to evaluate whether chance differences in clinical symptoms which occurred during randomization influenced the findings. Cronbach's alpha for the HADS-A was .87 and for the HADS-D was .82 in the present sample.

Stimuli

Three video vignettes featuring the same therapist wearing a National Health Service lanyard were created for this study. The therapist, who was female, mid-20s, and from a White British background was chosen due to being typically representative of therapists in the United Kingdom's Talking Therapy services. This therapist, a trainee clinical psychologist, had doctoral-level training in a programme with full CBT accreditation and over 2 years' experience of delivering Cognitive Behavioural Therapy, allowing her to present the pre-written scripts in a natural way. Cognitive Behavioural Therapy was chosen as the therapeutic modality as it is the most common form of psychological therapy provided in United Kingdom Talking Therapy services. The script and videos were piloted with several British Muslims known to the first author, including individuals who had professional experience of delivering therapy, including two Clinical Psychologists and a Play Therapist, three British Muslims who had no experience of therapy, and three British Muslims who had experience of therapy. Feedback from this stage included the consideration of language used, such as explaining the terms 'cognitive' and 'behavioural', providing practical information such as average duration and frequency of sessions and ensuring that religion was sufficiently emphasized in the experimental video. Feedback also pertained to technical and stylistic elements of the video, including lighting, and the background setting behind the therapist. All feedback was used to inform the final videos.

Baseline video

All participants were shown the baseline video, which was 1 min 59 s, in which the therapist explained the CBT model, including the building of a shared understanding based on patterns of unhelpful thoughts and behaviours, identification of goals and active and collaborative experimentation.

Control video

Participants in the control condition were shown a 44-s video, which featured the same therapist, who expressed their belief in the importance of understanding and integrating clients' general values in therapy.

Experimental video

Participants in the experimental condition were shown a 59-s video, which again featured the same therapist, who instead of referring to general values, explicitly mentioned the importance of discussing

religion in therapy if it was felt to be important. This is in line with Johnson et al.'s (2007) recommendation that therapists offer an explicit statement communicating their openness to exploring religion with clients as a method to integrate religion into therapy. The script of the experimental video was similar to the control video except the mention of religion.

Procedure

Participants first completed the Centrality of Religiosity Scale, the score of which determined the stratified random allocation to either the control condition or the experimental condition. Participants were randomized by a built-in tool on Qualtrics which uses the Mersenne method of generating pseudo-random numbers, a method of randomization used by the Qualtrics software based on algorithms that allow the random sequence to be stored and regenerated if necessary. Participants were blinded to the randomized nature of the study. They were not therefore aware of their condition assignment until being debriefed at the end of their participation. Randomization was performed via an automated process and thus could not be influenced by the research team.

After randomization, all participants were shown the same baseline video, in which they were given a brief description of CBT and what therapy entails. A built-in timer function on Qualtrics was used to ensure that participants could only move to the next stage of the study after the video had finished playing. Participants were asked to imagine that they were experiencing difficulties related to low mood or anxiety and speaking to the therapist in the video and subsequently completed baseline measures of anticipated alliance, treatment credibility and expectation. Depending on condition allocation, participants were then shown either the control video (mentioning general values) or the experimental video (explicitly mentioning religion). Participants then repeated the measures of anticipated alliance, credibility and expectation of improvement. After completing the measures for the second time, participants completed the HADS and demographic questions. Participants were also given the option to leave comments on their views of therapy with a non-Muslim therapist via a free textbox to generate further understanding into their perceptions beyond measures of expectancy, credibility and alliance. Given the richness of the qualitative data generated from this question, they were analysed seperately and will be presented in a forthcoming study. On completion, participants were shown a debrief form with a list of contact numbers if they felt distressed or would like further professional support.

Figure 1 details the procedure:

Analysis

The analysis was performed using IBM SPSS Statistics v27. Statistical assumptions were checked and met for each analysis. Demographic data were compared using chi-squared tests, and pre-experimental ratings for the outcome measures were compared using *t*-tests. Correlations were calculated using Pearson r correlations. For the primary outcome variable, change scores in anticipated therapeutic alliance ratings were calculated by subtracting total alliance scores at Time 1 (after the Baseline Video) from those at T2 (after the Control Video or Experimental Video). High and low religiosity groups were determined by a median split, the median being 66 in this sample. Group differences were analysed using 2 (low vs. high religiosity) × 2 (video condition allocation) between-subjects ANOVA.

RESULTS

A total of 361 individuals provided consent to participate. Of these, 64 participants did not start the study and 131 participants started but did not complete participation, leaving a total of 166 participants who completed the study. Data from 24 participants were excluded as they failed to

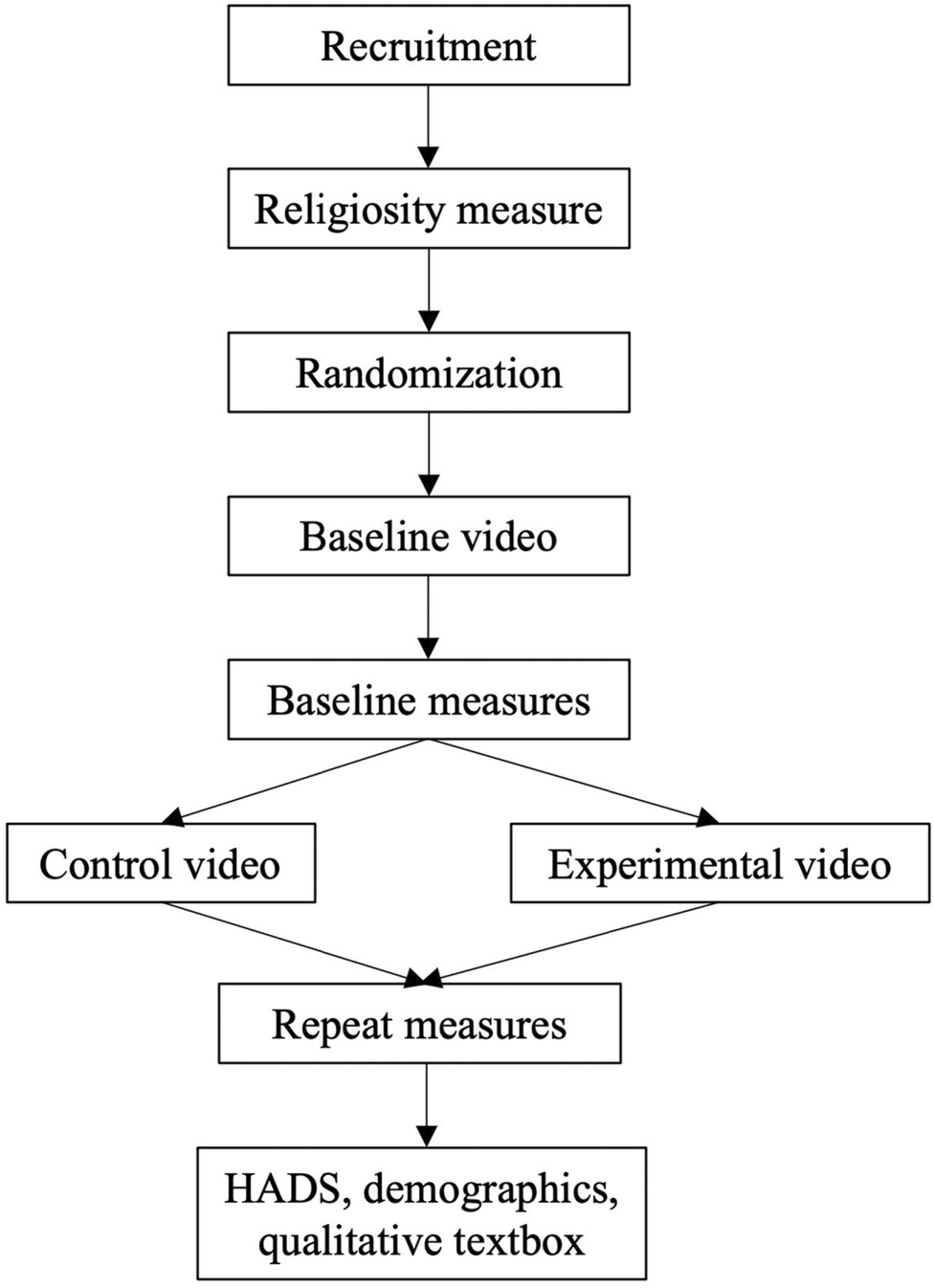

FIGURE 1 Flow chart of study design.

complete watching the videos before responding (due to an error in the inbuilt timer function), and a further 13 were excluded for having professional experience of *delivering* therapy, leaving a total of 129 participants. 68 participants were allocated to the control condition ($n = 40$ High Religiosity, $n = 28$ Low Religiosity) and 61 to the experimental condition ($n = 36$ High Religiosity, $n = 25$ Low Religiosity).

Descriptive statistics

Table 1 shows participant demographics including the distribution across ages, with 78.3% of participants between the ages of 21–50. Most participants identified as being Sunni Muslims (89.9%) and 65.1% of participants were female.

Comparison of groups for descriptive and demographic variables

Examinations of group differences suggested that they were comparable on key demographics. Table 2 shows descriptive data grouped by religiosity and study condition.

TABLE 1 Participant demographics.

Demographic variable	*N*	%
Age		
18–20	18	14.0
21–30	38	29.5
31–40	27	20.9
41–50	36	27.9
51–60	5	3.9
61–70	3	2.3
70+	1	.8
Prefer not to say	1	.8
Religious Sect		
Sunni	116	89.9
Shia	3	2.3
Ahmadi	2	1.6
None	7	5.4
Prefer not to say	1	.8
Ethnic group		
African	7	5.4
African Asian	4	3.2
Arab	10	7.8
Arab Asian	1	.8
British Asian	22	17.1
Asian Other or Asian Unspecified	9	7.0
Bangladeshi	11	8.5
Indian	6	4.7
Pakistani	42	32.6
White British	8	6.2
Other	5	3.9
Prefer not to say	4	3.1
Gender		
Female	84	65.1
Male	44	34.1
Prefer not to say	1	.8

TABLE 2 Participant descriptive data.

Variable		Control video ($n=68$)		Experimental video ($n=61$)	
		High religiosity ($n=40$, %)	Low religiosity ($n=28$, %)	High religiosity ($n=36$, %)	Low religiosity ($n=25$, %)
Age	18–20	4 (22.2)	4 (22.2)	9 (50)	1 (5.6)
	21–30	13 (34.2)	4 (10.5)	12 (31.6)	9 (23.7)
	31–40	18 (66.7)	9 (33.3)	10 (37)	8 (29.6)
	41–50	9 (25.7)	13 (37.1)	7 (20)	6 (17.1)
	51–60	2 (33.3)	1 (16.7)	0 (.0)	3 (50.0)
	61–70	0 (.0)	2 (66.7)	1 (33.3)	0 (.0)
	70+	0 (.0)	0 (.0)	1 (100)	0 (.0)
Sex	Male	13 (29.5)	9 (20.5)	14 (31.8)	8 (18.2)
	Female	23 (27.4)	16 (19)	26 (31)	19 (22.6)
Sect	Sunni	32 (27.6)	24 (20.7)	35 (30.2)	25 (21.6)
	Other	3 (60.0)	0 (.0)	1 (20.0)	1 (20.0)
Ethnicity	Asian	24 (35.3)	12 (17.6)	17 (25)	15 (22.1)
	Asian British	2 (9.1)	7 (31.8)	7 (31.8)	6 (27.3)
	Other	9 (25.7)	5 (14.3)	16 (45.7)	5 (14.3)
		***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**
HADS-A Score		9.11 (4.16)	8.04 (4.91)	7.65 (5.03)	8.93 (4.99)
HADS-D Score		6.39 (4.29)	6.20 (3.73)	5.13 (4.1)	6.57 (3.78)

Ethnicity was collapsed into three categories: Asian, Asian British and Other. Chi-squared tests indicated there was no significant association between religiosity and ethnicity, $X^2_{(2)}$, ($N=125$) = 5.25, $p>.05$, or between religiosity and sex, $X^2_{(1)}$, ($N=128$) = .11, $p>.05$. There was also no significant association between religiosity and sect, whereby sect was categorized into Sunni and 'Others'; ('unspecified' sect was not included), $X^2_{(1)}$, ($N=116$) = .978, $p>.05$.

Chi-squared tests indicated that there was a significant association between religiosity and age, $X^2_{(7)}$, ($N=128$) = 19.98, $p<.05$, where participants in the lower religiosity group had a mean age category of 3.19 (30-40 yrs), and participants in the higher religiosity group had a younger mean age category of 2.68 (20-30 yrs). Despite this, age was not significantly correlated with change in alliance ($r=.056$, $p>.05$), change in credibility ($r=.007$, $p>.05$), or change in expectancy ($r=.105$, $p>.05$), and was therefore not used as a covariate in the analysis. There was no main effect of religiosity on HADS-A scores $F(1, 125) = .015$, $p>.05$ or on HADS-D scores $F(1, 125) = .763$, $p>.05$.

Anticipated therapeutic alliance

Prior to the main analysis, anticipated therapeutic alliance was compared between those relatively higher and lower on self-reported religiosity at baseline (i.e., after the first video). These groups were not significantly different on this variable (high religiosity: $M=41.34$, $SD=8.01$, low religiosity: $M=40.38$, $SD=9.15$), $t_{(127)} = -.635$, $p>.05$. This indicated a similar starting point for religiosity groups on the primary variable before randomization to the additional video. Means are shown in Table 3 below, together with those for the secondary analyses.

The analysis next considered the impact of the two videos; change scores in anticipated therapeutic alliance ratings were calculated by subtracting total alliance scores at Time 1 from those at Time 2. A 2 (low vs. high religiosity) × 2 (video condition) between-subjects ANOVA was then used to compare

the change in scores of anticipated therapeutic alliances between the control condition and the experimental condition. In terms of change in anticipated alliance, the main effect of video condition was not significant, $F(1, 125) = .638$, $p > .05$. There was also no significant main effect of religiosity on change in anticipated alliance, $F(1, 125) = .217$, $p > .05$. There was no evidence of an interaction between participant religiosity and the allocated video condition $F(1, 125) = .004$, $p > .05$.

A paired-sample *t*-test showed a significant increase in therapeutic alliance from Time 1 to Time 2 across both video conditions. On average, participants rated the therapeutic alliance as higher at Time 2 ($M = 43.95$, $SD = 8.11$) than at Time 1. This increase in alliance rating was significant $t(128) = 5.946$, $p < .001$, indicating that increased exposure to the putative therapist may have positively impacted on the expectation of a good therapeutic alliance.

Credibility of treatment

At baseline, participants in high and low religiosity groups did not significantly differ in terms of credibility (high religiosity: $M = 18.86$, $SD = 4.21$, low religiosity: $M = 18.24$, $SD = 4.31$), $t(127) = -.802$, $p > .05$, indicating a similar starting point.

A 2 (low vs. high religiosity) × 2 (control vs. experimental video) between-subjects ANOVA to predict the change in participants' rating of treatment credibility did not show a significant main effect of religiosity, $F(1, 125) = .662$, $p > .05$. However, the main effect of video condition was significant, $F(1, 125) = 9.130$, $p < .05$. Participants in the experimental condition showed a greater improvement in rating of treatment credibility ($M = -1.97$ $SD = 3.49$) than participants in the control video condition ($M = -.43$, $SD = 2.38$). The interaction between video condition and religiosity was not significant, $F(1, 125) = .480$, $p > .05$, indicating that the inclusion of acknowledgment of religious values improved treatment credibility regardless of degree of religiosity.

Expectancy of change

At baseline, participants in high and low religiosity groups did not significantly differ in terms of expectancy (high religiosity: $M = 16.28$, $SD = 4.42$, low religiosity: $M = 16.27$, $SD = 4.73$), $t(127) = -.014$, $p > .05$, indicating a similar starting point.

A 2 (low vs. high religiosity) × 2 (control vs. experimental video) between-subjects ANOVA with the change in rating of expectancy as the dependent variable did not show a significant main effect of religiosity, $F(1, 125) = .012$, $p > .05$. However, the main effect of video condition was significant,

TABLE 3 Means and standard deviations of outcome measures.

			Control video ($n = 68$)	Experimental video ($n = 61$)
Variable			***M* (*SD*)**	***M* (*SD*)**
Change in alliance			−2.60 (5.50)	−3.44 (5.99)
Change in credibility			−.43 (2.38)	−1.97 (3.49)
Change in expectancy			−1.07 (2.40)	−2.22 (3.46)
	High religiosity ($n = 40$)	**Low religiosity ($n = 28$)**	**High religiosity ($n = 36$)**	**Low religiosity ($n = 25$)**
	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**	***M* (*SD*)**
Change in alliance	−2.78 (5.58)	−2.36 (5.49)	−3.67 (5.29)	−3.12 (6.98)
Change in credibility	−.4 (2.64)	−.46 (1.99)	−1.64 (3.28)	−2.44 (3.8)
Change in expectancy	−1.09 (2.69)	−1.05 (1.98)	−2.16 (3.13)	−2.31 (3.96)

$F(1, 125) = 4.767$, $p < .05$. Participants in the experimental video condition had a greater change in expectancy ($M = -2.22$, $SD = 3.46$) than participants in the control video condition ($M = -1.07$, $SD = 2.40$). The interaction between video condition and religiosity was not significant, $F(1, 125) = .034$, $p > .05$. This result is similar to the treatment credibility findings.

DISCUSSION

This study focused on the reactions of British Muslim participants to a White British therapist describing a specific psychotherapeutic intervention (CBT). The impact of the therapist acknowledging specific religious values in the context of developing a therapeutic relationship prior to delivering therapy was evaluated by randomization to conditions where the importance of incorporating religious values in therapy was or was not emphasized. Our first hypothesis that acknowledging religion as a value would improve expectation of treatment credibility, treatment expectation and anticipated alliance was partly correct; the acknowledgment of religious values in the description of therapy resulted in an improvement of scores on both treatment credibility and expectation of outcome, but there was no impact on anticipated alliance. Our second hypothesis that participants with a higher level of religiosity would show a greater increase was not supported: Religiosity grouping had no impact. There was, however, an increase in scores of expected alliance across both video conditions and across religiosity groupings.

These findings add to the limited literature on these issues. Shumway and Waldo (2012) found an interaction between level of religiosity and anticipated working alliance in their study which used a written consent form. However, they did not consider participants' level of religiosity as a variable when allocating to control or religion conditions. Similarly, Terepka and Hatfield (2020) found that Christian undergraduate students who were asked about their religiosity in an interview analogous to an initial therapy session experienced the interviewer as more empathetic, warm, understanding, experienced, trustworthy and friendly compared to participants not asked about their religiosity. Individuals with moderate and low levels of religiosity endorsed higher ratings of the interviewer when asked about their religiosity but this was not the case for those with high religiosity. Neither of these studies excluded participants with previous experience of therapy, which may impact responses above and beyond the experimental design.

An important feature of the present study was that the control video indicated that the therapist would respect their clients' values, while the experimental condition simply indicated that this would explicitly include religion. This very subtle difference in emphasis significantly positively impacted perceived effectiveness and credibility of treatment. Pre-existing religiosity did not interact with this effect, suggesting that the acknowledgement of religion may be effective for British Muslims across a range of religiosity. These findings are consistent with previous research (Meer & Mir, 2014), indicating that when working with Muslim clients, non-Muslim therapists should clearly demonstrate an openness to discussing faith. Furthermore, as increased exposure to the therapist also increased anticipated alliance regardless of condition, pre-treatment interventions involving the therapist providing more information could improve treatment expectancies.

Although these findings may on initial inspection appear unsurprising, and in line with our understanding that the incorporation of clients' values enhances the therapeutic encounter, they remain at odds with findings that some clinicians are reluctant to discuss religion in therapy (Magaldi-Dopman et al., 2011; Walker et al., 2004). Given the potential improvements in how religious clients may perceive therapy in terms of expectation and credibility, there is great value in acknowledging faith in clinical practice. The incorporation of religious beliefs in therapy involves therapists taking responsibility for engaging clients in these discussions without seeing their own epistemological position as truth (Carone Jr & Barone, 2001; Lee et al., 2022). To facilitate these discussions, therapists should have an understanding of the basic tenets and beliefs of their client's faith (Abu Raiya & Pargament, 2010) and express a willingness and openness to learning more. As when discussing other values in therapy, it is important

that these discussions are person-centred, and clinicians should hold in mind that there may be some religious clients who do not wish to bring faith into the therapy room.

Our findings also raise questions about the impact of acknowledging religion on anticipated alliance. Previous research suggests that more important than shared religious identity is whether therapists are perceived as open, understanding and accepting of clients' views (Post & Wade, 2009; Wade et al., 2007). It may be therefore that in the control condition, the mention of incorporating and attending to the clients' general values was enough for clients to perceive the therapist as open to discussing religion. Another explanation could be that clients across both groups in our study did not expect for religion to be addressed in secular services. Van Nieuw Amerongen-Meeuse et al. (2021) found that Christian patients in a secular mental health clinic who welcomed religious conversations but found that this need was not met in treatment reported lower levels of treatment alliance than clients whose needs were met or those clients who did not express a desire to discuss religion. It may therefore be that British Muslims do not expect to discuss religion in secular therapy services.

This study may have been strengthened by including data on participant's education level or intergenerational differences, both of which may be variables of interest. Relatedly, only English-speaking participants with internet access and familiarity with online forms could participate in this study: this particular group is likely to have more exposure to information about therapy and mental health services online. Therefore, these findings may not represent others in the British Muslim community who do not have access to these resources. Moreover, as a greater number of females participated in this study (65.1%) as compared to males (34.1%), these findings may be more reflective of British Muslim women's perceptions of treatment expectation, credibility and alliance. Finally, although the use of video vignettes is a strength of this study, videos do not provide insight into the complexity of an actual therapeutic encounter. Future research may show actual segments of therapy to enable participants to better judge anticipated alliance with the therapist.

In terms of research implications, further work is needed to understand the relationship between anticipated alliance and credibility and expectancy. This study found significant effects in credibility and expectancy, but not alliance; future research may test this relationship more explicitly to inform how changes can be made at a clinical level to have the greatest positive impact on perceptions of therapy. There is also a need for studies testing the predictive validity of the future tense versions of the WAI which would help strengthen its use in studies examining how participants anticipate the therapeutic alliances to develop. Qualitative studies may help to situate these factors contextually; in particular, a better understanding of how individuals from religious backgrounds perceive secular therapy services may shed light on whether the way these services describe treatment is a barrier to access for this group.

Although this study was conducted on a British Muslim sample, there are universal implications to acknowledging and incorporating religion into therapy for clients across a range of religious backgrounds. These findings may be used to inform clinical practice on an individual level through the incorporation of religion into assessment and formulation to inform goal setting and interventions but may also inform how secular mental health services describe their therapeutic offers to religious groups in a way that improves perceived credibility and expectancy. These findings may also pertain to other issues of difference between client and clinician, such as cultural factors, and this may be extended to clients from a range of minoritized backgrounds.

In conclusion, this study found that treatment credibility and expectancy of outcome for a CBT intervention were improved by showing participants a video in which a therapist explicitly acknowledged the importance of religion.

AUTHOR CONTRIBUTIONS

Hibah Hassan: Conceptualization; data curation; formal analysis; writing – original draft; methodology; project administration; writing – review and editing. **Sarah Lack:** Conceptualization; supervision; writing – review and editing. **Paul M. Salkovskis:** Conceptualization; data curation; formal analysis; methodology; supervision; writing – review and editing. **Graham R. Thew:** Conceptualization; methodology; supervision; writing – review and editing.

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CONFLICT OF INTEREST STATEMENT

Authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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