

# **Mental Health and Religion: A Guide for Service Providers**

**E. Paul Chapple**

## **Abstract**

It is apparent that the vast majority of research on this subject has been conducted in the U.S.A. However, there are an increasing number of publications in the U.K. and elsewhere. Despite the abundance of published studies, it is difficult to prove causality in the effect of religion on mental health although the interrelationship can be effectively demonstrated. The subject of health professionals making clinical interventions in the area of this interrelationship is widely studied and discussed.

Selection of the data generation instrument for this qualitative study is discussed. Sampling is purposive for those suffering from a mental disorder but randomised for religiousness. The procedure used at interview is described and the resulting data is analysed, synthesised and the results listed.

An undoubted link between religion and mental health is seen from the literature review and the qualitative study performed. The religious dimension is very important to many people suffering from mental disorders and should not be ignored by health professionals. Recommendations are made for mental health service providers which consist in ensuring the religiousness of clients is considered but that sensitivity is exercised, so that clients are given time and space both to express their religiousness and to discuss this with informed professionals if they so desire. A UK. wide controlled study is recommended.

## **Introduction**

Within the UK National Health Service (NHS) all treatment is expected to be evidence-based, the 'gold standard' reference databases for the NHS being found in the Cochrane Library (Cochrane 2002). Cochrane reviews quantitative research, typically randomised controlled trials (RCTs), throughout the whole healthcare field. A search of Cochrane databases for 'religion AND mental health' reveals only three citations of which two are relevant here.

The first (Razali et al. 1998) examines the effectiveness of incorporating religious-sociocultural components in the management of patients with anxiety and depression who have strong religious and cultural backgrounds. The study indicated a need for more sensitivity to religious-sociocultural issues in mental health but was rather inconclusive. The second, from the Cochrane Schizophrenia Group (Roberts et al. 2002), looks specifically at prayer for the alleviation of ill health. The conclusion was that the data in the review were inconclusive but further study was justified.

The concluding comment from the abstract of the second review was interesting: 'If any benefit derives from God's response to prayer, it may be beyond any such trials to prove or disprove.' If this is the case it has not prevented 'a large corpus of work in this area' (Schumaker 1992 p.3) and that was during the 1980's. As we shall see in our literature review, despite the paucity in Cochrane (2002) there is an increasing interest in research in our chosen area of interest.

## Literature Review:

### USA literature

Barker (2000) (p. 88-90) reviews what he calls 'a multi-author review of most of the literature on religion and mental health' (Schumaker 1992), and claims that the editor concludes that religion appears to be beneficial to mental health. In reality, Schumaker in his *Introduction* clearly indicates the conflicting views among researchers as to the role of religion in the whole disease area of mental illness. These range from it 'affording solutions to a wide array of situational and emotional conflicts' to religion being described as 'mental sickness' itself. The usefulness of this book, in fact, is increased by the contributors not hesitating to point out the difficulties in research into the subject, including the appropriateness of study populations and actual measures used. For instance, Masters and Bergin (1992), reviewing studies of the previous twenty years (Chapter 17), admit that the research reviewed was not carried out on persons suffering from mental illness but claim that their findings will be useful in providing information about mental health.

One of the contributors to Schumaker (1992) is Harold G. Koenig, Professor of Psychiatry at Duke University. Although Schumaker conceptualises religion and mental health in his *Introduction*, Koenig (1992) sees the need to define religion for his research purposes and uses the relatively simple definition of the Concise Oxford Dictionary:

'the human recognition of superhuman controlling power and especially of a personal God entitled to obedience, and the effect of such recognition on conduct and mental attitude'.

This is a suitably narrow definition for research purposes and will be adopted in this study. Koenig sees that church attendance (extrinsic religion) may just be a marker of physical health and ability and have little to do with mental health (p.180). He had found that religious beliefs and practices:

'appear to buffer against the stresses of hospitalisation and medical illness. Both depressive symptoms and major depressive disorders were significantly less common among religious copers, who were also less likely to become depressed over time' (p185).

By the time Koenig compiled his own 'Handbook of Religion and Mental Health' (Koenig 1998) he was able to report a 'virtual explosion of research' into the subject. He saw the need for this handbook as a 'source-book that both clinicians and educators can depend on' (p. xxxi) and described the subject as a new research frontier (p31). In the chapter 'Future directions in research' McCullough and Larson (1998) recognise that research into the area of religion and mental health has acquired 'legitimacy' (p96). They will not go further in their summary, however, than to say that the 'vigorous activity' in the area has given rise to an awareness that an important relationship *perhaps* exists between religious faith and mental health (*our italics*).

Koenig himself shares in the longest chapter in the final section, which is on Clinical Applications. Koenig and Pritchett (1998) give:

'practical information and guidelines that will help the therapist address religious issues in psychotherapy and, where appropriate, utilise the patient's spiritual resources to enhance mental and emotional healing'.

The authors admit that they are treading on 'treacherous ground' but claim that addressing spiritual issues is becoming more accepted. The latter claim is substantiated by reference to the inclusion of sensitivity to religious beliefs in American medical professional standards. However, the application of the latter standard does not necessarily lead to addressing spiritual issues. The author of a chapter on 'Integrating religion into education' (Bowman 1998) states that 'scientific literature on teaching mental health trainees about religion or spirituality is sparse' and she therefore has to rely on her own experience to make recommendations.

Koenig and Larson (2001) acknowledge the lack of research into psychiatrists addressing spiritual needs. The authors refer to their own clinical experience in recommending religious history taking in all patients but admit that 'the vast majority of psychiatrists will feel neither comfortable nor competent to address religious issues in depth'. They realise that this may need involvement of a chaplain or other religious professional, though they point out that psychiatric patients are a group to whom chaplains have had only limited access. This is certainly the position in the UK. where there are very few chaplains involved in mental health work. The sentence with which Koenig and Larson (2001) end their joint paper sounds rather wistful:

'The research presented...suggests that the twenty-first century may see a narrowing of the wide gulf that separated religion from psychiatry in our recent past'.

In the editorial to the edition of the journal in which the above joint paper appears, Breakey (2001) appreciates the importance given to religion and spirituality by most patients in psychiatric practice and wonders why the subject is avoided by psychiatrists. He understands the problem of most psychiatrists as one of ignorance rather than hostility, as with Freud. He does, however, identify a problem that some religious people have with psychiatry as being one of caution or even distrust, some even perceiving the discipline as anti-religious. Again the author understands this problem as partially due to ignorance, but due to the professionals' ignorance, he sees that the distrust is sometimes justified. Just as Griffith and Griffith (2002) see the debate between science and religion as a problem for mental health professionals, so Breakey (2001) understands how psychiatry's increasing scientific base may exacerbate the distrust of religious people.

Clinicians are advised that they should be asking patients about their use of religion in coping with their illness (Harrison et al 2001). The reasons given, however, credit the clinician with some ability and understanding in religious matters, otherwise how can s/he 'work through troubled areas in these concerns'? The patient may believe that the clinician is treating the 'whole person' but it may be rather ingenuous of the clinician to enquire about the patient's coping strategies, hoping to reinforce them, without having had any training in religious coping. It is true that

'religious persons use their faith to give meaning and purpose to negative events that happen to them'

but will many clinicians be able to make sense of how a religious patient is able to understand their illness and give meaning to it? The authors demonstrate their own

misgivings by finally recommending that a patient may be referred to a pastoral counsellor or a chaplain.

New guidelines, however, were introduced by the Accreditation Council for Graduate Medical Education (AGME) in 2001 (Puchalski et al 2001). Training must include an understanding of religious/spiritual factors as well as cultural diversity, including religious/spiritual diversity. The American Psychiatric Association is also calling for psychiatrists to maintain respect for their patients' beliefs. The authors report that the National Institute for Healthcare Research (NIHR) has been examining possible links between spirituality and health and developing corresponding courses in American medical schools. They also report on the initiative supported by the John Templeton Foundation when psychiatrists from various faith traditions came together to produce guidance in clinical training (Larson et al 1996). Kroll and Erickson (2002) report that the Psychiatric Residency Review Committee has issued a mandate requiring the inclusion in the training curriculum of a course on religious and spiritual factors in health. They, however, raise doubts about the inclusion of such a topic in a scientific curriculum. The Editorial Review to this and other papers (Fulford 2002) notes that this paper indicates renewed cross-disciplinary contact after nearly a century of mutual neglect. The reviewer also notes the formation of a Spirituality Group in the Royal College of Psychiatrists of the UK. If trainers competent in both mental health and religious issues can be found then this may be a way forward to mutual understanding but it will be easy to widen the current divide if the subject is not handled with sensitivity.

A study specifically involving The Church of Jesus Christ of Latter-day Saints (LDS) (Merrill and Salazar 2002) demonstrates the generic relationship between mental health and religion. Members of this Church, commonly called Mormons, live by a strict code governing health, education, and life in general. The study examined the mental health of interviewees throughout the state of Utah and compared results for active Mormons and less active Mormons, with active and non-active members of non-LDS religions, and with people of no religion. The authors found that the chance of experiencing mental illness was greater for the less active members of LDS and non-LDS religions and indeed for those of no religion at all. For those associated with religion, church activity was inversely related to seeking help for emotional problems. However, from this literature review so far, it may be deduced that 'experiencing mental illness' and 'seeking help for emotional problems' are not necessarily synonymous. The review has indicated already that those with an active religion, though suffering mental illness, may cope better than the irreligious person.

That opposition to the mix of mental illness and religion is still alive and well is demonstrated in a book review (Gallaher 2001). The author describes his experience as a professional in a New England mental hospital where a church service was traditionally offered every Sunday. In addition to this, several patients decided to ask for a midweek prayer meeting such as they were used to in their own church. Though the hospital director was sympathetic to this, he canvassed the professional staff and found widespread opposition. Clinicians argued that the guilt, shame, and depression from which some patients were suffering might be traced to earlier experiences of religion, apart from others who were religiously symptomatic, preoccupied, and delusional. The request for the extra meeting was declined even though no evidence was produced for the professionals' argument. The author refers to an 'uneasy juxtaposition' between mental health and religion even though he feels that the mental health professions function in cognitive territory not far from the imponderable, inherently unverifiable claims of religion. The relationship between mental health and religion, in that juncture, easily comes down to tension and competitiveness rather than the benign tolerance of two ships that pass each other in the silence of the night.

These comments further highlight the need for this divide to be bridged, ideally by more evidence based practice in mental health and religion.

Bussema and Bussema (2000) found that amongst their study population (n=17) in psychiatric rehabilitation, a common theme was the lack of emotional and social support from the local churches. The authors also observed that in psychiatric rehabilitation most practitioners overlook or neglect the spiritual needs of patients. They ask the question if, as in the case of their study population, neither the church nor psychosocial rehabilitation programmes are addressing religious and spiritual needs of persons with a severe psychiatric disability, who else can help? They see the need for a religious needs assessment with pastoral counsellors, chaplains, and pastors being invited to become members of multidisciplinary teams. The authors see this as a positive way of heightening awareness in other mental health professionals of the religious and/or spiritual needs of patients. They believe that:

‘professionals with at least an understanding and familiarity with the consumers’ religious traditions would facilitate the incorporation of faith issues into the therapy process. Not only can pastors contribute to therapy/rehabilitation outcomes, but rehabilitation and therapeutic services can become a resource for pastors and family members in understanding the relationship between faith and psychiatric disability’.

‘Spirituality discussion groups’ are also suggested, since the authors found that patients (consumers) were most comfortable discussing faith issues with fellow patients.

A very real difficulty remains about clinicians being equipped to discuss matters of religion with their patients and it is unlikely that a religious professional will always or even often be available, especially in the area of mental health. Carone and Barone (2001) recognise the importance that religious beliefs and practices will have in the lives of many psychotherapy clients. They recognise that although religion has a high allegiance among the public in the USA (55% of Americans rate it as very important – Gallup 1993), mental health professionals are more likely to be non-believers. The professional will often be in fundamental disagreement with her/his clients’ beliefs but the authors believe that religion must be regarded as an important part of the culture of the client and a non-judgemental attitude must prevail as with other cultural attitudes. The professional must concentrate on mental health, admit her/his ignorance of religious matters, and rephrase the problem if possible as one in which s/he has expertise. Clinically, this is a convenient way forward but if at all possible the client should be referred to someone with the necessary expertise.

Some of the foregoing research has been criticised by Sloan and colleagues (1999). The authors indicate certain methodological weaknesses such as control for confounding variables and other covariates, control for multiple comparisons and conflicting findings. The ensuing correspondence indicates little support for their views (Koenig 1999a, Rabin 1999, Roper 1999, and Tucker 1999). Koenig devotes a complete editorial to a rebuttal in his own journal (Koenig 1999b). Sloan and colleagues (1999) do raise an interesting ethical issue, however:

‘When doctors depart from areas of established expertise to promote a non-medical agenda, they abuse their status as professionals. Thus, we question inquiries into a patient’s spiritual life in the service of making recommendations that link religious practice with better health outcomes’.

Roper (1999) sees the doctor as 'facilitator', referring patients to religious 'experts' such as priests and rabbis. Tucker (1999) sees the ethical issues as important but does not have a problem with giving encouragement to the patient to pursue the spiritual. There is no doubt an ethical problem to consider and without suitable training health professionals face a clinical risk situation.

## **UK Literature**

Loewenthal's book (1995) is not meant to be a comprehensive review of the literature (p.1) but takes the form of a case review. The author draws from her own cases as a psychologist and those of others to illustrate both potential benefits and problems with the interaction between religion and mental health. For example, there is the case of forty-five year-old E. (Littlewood and Lipsedge 1989 cited in Loewenthal 1995 p.165-169), a nursing auxiliary and a committed Pentecostal Christian, who had had psychiatric treatment a short time before the described incident. After attending church one Sunday, E. had started work on the ward and began exhibiting bizarre behaviour involving quasi-religious actions. The authors describe their difficulty, when summoned to attend the situation, in separating E.'s experience into that of mental illness and that of religion. They ask if her church involvement had exacerbated or even caused her mental illness, or if, in fact, it had prevented her presenting earlier in life. Loewenthal (1995) helpfully examines reasons why religion may or may not be conducive to mental health. For instance she sees guilt that can apparently be caused by religion as more likely to be caused by the way the religious beliefs and practices were taught (p.135). On the other hand the author discusses the benefits of social support and gives evidence that this may be provided by religion (p.142).

Loewenthal (1995) usefully links psychology theory with religion. For example she observes that object-relations theory has helped in psychotherapy (p.41), comparing a relationship with God to other relationships, and quotes Rizzuto (1974) who saw adults relating (or not) to God in four ways:

- having a God to whom they relate in various ways – 'I have a God'
- wondering whether to believe or not in a God whom they are not sure exists – 'I might have a God'
- amazed, angered or quietly surprised to see others deeply invested in a God who does not interest them – 'I do not have a God'
- struggling with a demanding harsh God they would like to get rid of if they were not convinced of his existence and power – 'I have a God but I wish I did not'

This contributes to explaining the attitude of some health professionals to their patients, a subject to which Loewenthal (1995) devotes a whole chapter (p.156-184). The author summarises how she sees the extreme views of patients and professionals:

- the clients say that most mental professionals are an irreligious lot, who categorize every bit of religious behaviour as a delusion, an obsession or a compulsion, or as some other manifestation of mental illness caused by religion;
- the professionals say that they are a sensitive bunch, who admit to having difficulties in sorting out which behaviours and feelings are pathological and which are related to healthy religiosity; they (the professionals) are

sensitive to religious issues and would like more information, so that they can make more informed judgements.

There is little doubt that a more extreme view is sometimes taken by the professional (Rizzuto 1974). The patient's religious orientation can be at least an irritant, if not a definite obstacle, to the professional pursuing diagnosis and/or treatment.

Bhugra (1996) claims to attempt to represent the beginning of the dialogue between two neighbours (religion and psychiatry). Since the UK is far behind the U.S.A. in the field of mental health and religion, this may be true but only so far as the UK is concerned. (The field of religion and psychiatry is a different, if related, field). However, so far as the contemporary interaction between religion and mental health is concerned, Barker's is the most relevant chapter in Bhugra (1996). The author claims that New Religious Movements (NRMs) have drawn from all manner of ancient and modern philosophies and ideologies. It is true, however, that some or all of these movements may not fit into the Concise Oxford Dictionary definition of religion adopted from Koenig (1992). Barker (1996) sees that the NRM should not be blamed, as they sometimes are, for all the mental illness suffered by members. Cases that have been investigated have often demonstrate a history of mental illness prior to a person joining the movement (p.132). The author makes the valid point that a person possessing a certain belief, however strange it may seem to most people, must not be automatically be diagnosed as mentally ill. She does acknowledge the potential difficulty, however, of assessing 'the sanity of people who have seen visions, heard voices or had unusual experiences which might be called religious'. This is not, however, only a problem with NRM's; the same problem could be found with members of orthodox religion. Finally, the author warns that it may be a family member or friend of someone joining a NRM who needs psychiatric help for symptoms of anxiety, fear or guilt, rather than the member of the NRM (p.134).

Some readers may feel that this study of mental health and religion seems too narrow and it should embrace all forms of spirituality. Swinton (2001) takes care to assure us that, whilst institutionalised religion is becoming less popular, people are not becoming less spiritual (p.11). He lists the central features of spirituality and gives them the synonym 'spiritual needs' (p25). Spirituality and spiritual needs have become a frequent topic in health journals and especially prominent in the nursing literature. A recent editorial (Draper and McSherry 2002) questions, however, whether the topic has any independent existence outside religion. The authors suggest that an adequate vocabulary already exists to include the existential dimension without the need to invoke spirituality. Swinton (2001) (p.25) argues that spirituality should be taken seriously since

'Although it may not fit neatly into the current scientific paradigm, as one encounters such language, one experiences a deep, intuitive sense of affirmation that these desires refer to dimensions that include, yet at the same time, transcend psychological explanation. Of course the idea of intuition and intuitive knowledge is not popular in an atmosphere that thrives on evidence-based practice, with evidence tending to be understood in narrow, positivistic terms'.

As this book is directed to mental health carers (p.9) the author is correct in stating that the atmosphere (of the National Health Service or NHS) thrives on evidence – based practice. The NHS Plan (DH 2000) demands practice that is evidence-based and any concept not evidence-based will not be encouraged within the NHS. This attitude is justifiable in the context of patient care since the accepted definition of such practice is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients (Sackett et al. 1996).

In the book (Swinton 2001), spirituality is described as a 'slippery concept" (p.12) and we are told we will have to be comfortable with uncertainty and mystery (p.13). The illustration then quoted, however, uses the image of the Holy Spirit from the Judaeo-Christian religions. The previously carefully defined terms of intrinsic and extrinsic when related to religion (p.29) are later used, but not defined, under the heading of 'Practising spiritual care'. The case study described, however, is limited to traditional religion (p.146). A whole chapter, 'Living with meaninglessness' (p.93-134) is devoted to a detailed account of one study of spirituality and mental health but the author points out that all participants in the study were committed to the Christian faith (p.111). If the main theme of the book is in fact that of religion and mental health care it would be better stated thus.

Swinton (2001) does, however, include some valuable discussion on spiritual care compared to medical, nursing, and psychological treatments in Chapter 2 and the literature review (Chapter 3) is particularly useful. Literature is included which is often passed over by other reviewers such as the inclusion of Shams and Jackson (1993), a British study where the authors found that involvement in a religious community can offer emotion-focused coping, problem-focused coping, and social support and therefore can help protect from the psychological effects of unemployment. Excellent detail of qualitative research is given in Chapter 4 with extracts from the interviews giving a depth of insight into the spiritual, existential, physical, psychological, and relational aspects of depression. One useful insight provided by the interviews of the study shows the desire of someone, with religious commitment but with a clinical depression, to experience empathy and understanding from carers even if they do not share the beliefs of the patient (p.127). This necessary emphasis is expressed in another new book from the U.K. 'The task of the therapist...is to be 'with' patients in their moments of hopelessness' (Watts 2002 p.140). This can be a challenge for the non-religious carer but one to be overcome professionally. Therefore, just as Koenig's publication (1998) appears as a 'handbook' of mental health and religion and probably can function as such in the U.S.A., Swinton's (2001) could be useful as a 'handbook' for the U.K.

It is encouraging to find UK. psychiatrists recommending the inclusion of the religious beliefs of patients in clinical psychiatric assessment (Lawrence and Duggal 2001). The authors see the need for a non-judgemental approach and believe that this will require special training. In their study of religious delusions in UK. schizophrenic patients, Siddle and colleagues (2002) warned that prejudice might be shown by non-religious psychiatrists towards religious ideation in their patients. This emphasises the need for special training.

If people with religious beliefs and mental illness have difficulty relating to mental health professionals, it would be hoped that they could find support within the Church. A lack of support is reported in the Bussema and Bussema (2000) study in the USA., however, and the situation in the UK. needs to be examined. The Royal College of Psychiatrists (R.C.P.) undertook a survey of attitudes to mental illness throughout the UK. (Crisp et al 2000). This revealed a high degree of prejudice against mental illness. A survey was carried out using the R.C.P. questionnaire within one English church congregation (Gray 2001); a less stigmatising and more sympathetic attitude was found. It would be useful to know how prevalent this finding is in church congregations generally throughout the U.K.

With regard to the relationship of mental health and religion in the UK. one final study is revealing. The main observation of a study in the effectiveness of religious coping with depression (Loewenthal et al. 2001) is that religious coping was seen as relatively ineffective. However, when the method used in the study is examined, it can be seen that the results may be skewed by several factors. A questionnaire was completed



by 282 volunteers (average age 24.6 years), of various religions or none, all on UK university campuses. The volunteers were asked to grade themselves according to whether they were 'never depressed' or 'always depressed'. This use of self-diagnosis can be misleading and can lead to confusion between clinical depression and non-pathological sadness. Also, the two clinical categories are too extreme and coarse to give useful results. Another criticism is that the average age does not allow enough life experience to answer questions about coping strategy and, finally, 20% of the volunteers were of no religion, and thus the score of any positive religious coping is automatically reduced.

### **World literature**

A study that is stated to be the first to examine religious commitment among psychiatric in-patients in Canada (Baetz et al 2002) claims to indicate that some religious practices may protect against the severity of mental illness. The authors have gone into more detail than is the case with most studies and have attempted to distinguish the effects of itemised religious practices and beliefs. They found that worship attendance correlated with positive effects on more mental health measures than any other practice or belief, while fundamentalist beliefs such as a literal belief in the Bible had no significance. More attendance at worship services had a positive association with a lower incidence of depression, a shorter hospital stay, a lower rate of current and lifetime alcohol abuse, and greater subjective satisfaction with life. Prayer frequency, intrinsic religiousness (reported importance of religion in life), and religious coping all had a positive correlation with some outcomes. The authors recognise that a sample of 88 patients at one site limits the usefulness of the study. More importantly they acknowledge that causality cannot be determined; this may be the reason for the apparent confusion between extrinsic and intrinsic religiousness. Many of the studies mentioned in this critical review suffer from the same problem - when positive outcomes correlate positively with certain religious variables they still cannot be said to be the cause of those outcomes.

A pan-European study (Braam et al. 2001) included two approaches: a comparison of five countries relating depression to religious practice, and an approach in eleven countries, relating depressive symptoms to the religious climate. The first approach yielded the finding of lower depression rates associated with regular church attendance. The authors rightly ask, however, if the results could be due to physical health status and social ties. The second approach related high church attendance (all Roman Catholic countries) to low-level depression, but to higher depression scores in Protestant, low church-attendance countries. It should be noted that the authors realise that results may be affected by cross-national differences such as economic and social factors and may not be solely related to religious issues.

An Egyptian study (Atallah et al. 2001) looked at changes in frequency and pattern of the manifestation of psychiatric symptoms of a religious nature over 22 years, and attempted to relate these to fluctuations of emphasis on religion. The authors reviewed literature that demonstrated a change in the incidence of symptomatology with national social, political, and religious change in other countries. For example, one study they cite (Klaf and Hamilton 1961) shows that in the 20<sup>th</sup> century West, religious symptomatology dropped by two thirds compared to its 19<sup>th</sup> century level. It was assumed that this was because of the decreased emphasis on religion in the West. Atallah and colleagues had forecast an overall rise in rates of religious symptoms over the 22 years of the study because of an increase in emphasis on religion. Religious behaviour was shown to have increased overall during the period and religious hallucinations were shown to have increased proportionately. The authors see though

that what are usually described as religious symptoms are variations and exaggerations of commonly held beliefs and practices and reflect the prevalence of 'normality' in the larger society. This can be a major problem with assessing pathological behaviour and, as above (Siddle et al 2002), prejudice can be shown against religious symptoms.

Finally, in this critical review, a study from India examines the influence of religion on relatives caring for people with schizophrenia (Rammohan et al. 2002). Sixty patients and their carers agreed to take part: all carers were Hindu and, according to Juthani (2001) Hindus expect their religious beliefs and practices to contribute to positive health. 23% of the carers had originally attributed the illness of their relative to religious causes such as black magic and evil spirits (subsequently 8%) while 38% blamed biological causes (subsequently 53%). The remainder thought psychological causes such as stress or conflict within the family were to blame. 33% had tried religious methods of treatment before medical help was sought. Almost all of the carers felt that religious coping had helped but the results showed that religious belief rather than practice was more effective in reducing the stress of caring. This emphasises the important practical results of religious beliefs in caring (Koenig 2001).

### **Problem Statement**

It has been seen that a definite link is often claimed in the literature between a person having religious beliefs and practices, often called 'religiosity' or 'religiousness' and her/his positive mental health. Also, among those who suffer from mental illness, this religiousness is sometimes claimed to help with coping. It has also been seen that it is claimed in some literature that health professionals should take a patient's religiousness into account in their assessment and treatment. Further work needs to be done on these claims, however, especially in the UK.

This exploration may be expressed as a problem statement in the form of aims and objectives:

#### **Aim:**

To produce a guide for mental health professionals, trainers, and managers on the relationship between mental health and religion

#### **Objectives:**

To investigate:

- how the mental health of a person may be affected by her/his religion
- how and by what means the mental health of a person may be influenced by the religion of other persons or organisations
- how a person's own religion may be affected by his/her own mental health

### **Methodology**

It was judged earlier that the principle of evidence - based medicine (EBM) according to Sackett and colleagues (1996) was reasonable to ensure a good standard of patient care. However as the demand for more EBM has increased, especially through the last decade, dissenting voices are being heard. Reviewing drug development, an internationally acclaimed neuropsychopharmacologist had to say:

'EBM has become synonymous with randomised, double-blind, placebo-controlled trials (RCTs) even though such trials usually fail to tell the physician what he or

she wants to know – which drug is best for Mr. Jones or Ms. Smith, not what happens to a non-existent ‘average’ patient. (Lasagna 1998).

A former Secretary of the British Association of Psychopharmacology warns that:

‘The perception now is that new evaluative methods have pushed bad medicines out of the arsenal. In fact there is every reason to suspect that RCTs are pushing good therapies out of health care. Psychiatric units that once had active occupational therapy sections and social programmes are now reduced to boring sterile places where only things that have been ‘shown to work’ happen. Patients are not exercised, nor taken out on social activities, nor involved in art, music, or other therapies. If they leave hospital for psychosocial reasons, it is likely to be because of boredom’ (Healey 2001).

The fault, however, is not with EBM as such but in equating it strictly with RCTs, as if this was the only kind of admissible evidence. Long (1998) informs us that research and development in the NHS depends on the hierarchy of evidence model, headed up by the RCT (p.91). This completely ignores qualitative research methods with its data collection methods of interview and questionnaire, for example. These methods involve research in a natural rather than experimental setting (Ziebland and Wright 1997 p.104) and give:

‘new hope to the discovery of extremely covert, subtle, and subjective realities and truths about the meaning and expressions of health in individuals’ (Leininger 1985 p.3).

This hope is what is required in this study and qualitative research is seen as the most appropriate method of study.

## **Ontology**

The approach to methodology says much about the approach to ontology. The fact that truth may be covert, subtle, and subjective (Leininger 1985) means that its legitimate source may therefore be people. The RCT demands that if people are used in research they must be controlled and manipulated, however ethically acceptable, in unfamiliar or artificial settings, and that the researcher must be non-involved and detached from the subject. The subject under examination in this case demands that the researcher is involved with subjects and participates with them so that s/he can find out the truth as the individual experiences it. It may be experienced for example as memory, thoughts, or understanding, and these may result in behaviour, relationships, or actions. As Mason (1996 p.39) puts it, we see that these ‘are meaningful properties of the social reality’ we are exploring.

## **Epistemology**

A suitable epistemological position, as Mason (1996) sees it, would be to accept that interacting with people by talking and listening to them is a legitimate way of collecting or generating data. The author emphasises that during interview, for instance, people’s experiences can only be recounted and not relived. Another factor that could be important epistemologically is that our research is concerned with mental health and we

would be interacting with people often suffering from severe mental illness. Clarke (2001) asks the question:

‘can there be an objective aspect to the unconstrued thoughts of the psychotic? (p160). In realist science ‘objective’ is equated with non-subjective.....How can I investigate a person’s experiences if we are both deprived, by its very nature, of the normal means of discussing it?’

His answer makes ontological and epistemological sense:

‘One can rest with the participatory framework which affirms that experience is experience, and the business of living is about working with others concerning what is construed and shared (p.160).

## **Ethics**

So far as an approach to treatment and care in healthcare is concerned, the author has stated his position (Chapple 2002 p.2). This is based on the four-principles approach (Beauchamp and Childress 1989 cited in Beauchamp 1994 p.3), being those of:

- Beneficence (the obligation to provide benefits and balance benefits against risks)
- Non-maleficence (the obligation to avoid the causation of harm)
- Respect for autonomy (the obligation to respect the decision-making capacities of autonomous persons)
- Justice (obligations of fairness in the distribution of benefits and risks).

To these may be added the right to privacy and confidentiality (Polit and Hungler 1985 p.15) whilst clinical research must also have value and validity (Emanuel et al. 2000 p.2701).

These principles are evidenced in the consent form (Appendix 3) and the information leaflet (Appendix 4) given to each volunteer in this study. The submission to the Northumberland Local Research Ethics Committee is at Appendix 1 and a supplementary explanatory letter to the Committee at Appendix 2.

## **Research Method**

### **Design**

In 1996 the Mental Health Foundation carried out ‘a survey of how people in emotional distress take control of their lives’ (Mental Health Foundation 1997). A questionnaire was sent out nationally and 401 completed forms were received, questions being asked about coping strategies with one section asking specifically about religious or spiritual beliefs. The response indicated that religious or spiritual beliefs were important for over half of the people in the survey. This was only the first phase since the Mental Health Foundation then felt that this area and two others required ‘further in-depth investigation’ (Mental Health Foundation 2000 p.5); the chosen instrument for this second phase of research was the interview.

These two phases are good examples of the use of data collection instruments. The questionnaire was used as a quantitative tool, based on the numbers of people answering questions in different ways, and qualitatively using the comments recorded in open spaces on the questionnaire. The instrument was suitable for this wide-ranging, fairly superficial survey. It seems surprising, however, that respondents were prepared to answer a good number of open-ended questions. Hurst (2002) considers the questionnaire to be a quantitative instrument, and Polit and Hungler (1985 p199) find that questionnaires rarely have more than a handful of open-ended questions. The latter authors observe that:

'The major drawback of closed-ended questions lies in the possibility of the researcher neglecting or overlooking some potentially important responses'.

The interview was the correct instrument to carry out the in-depth follow-up investigation since questions can be more easily open-ended which allow for 'a richer and fuller perspective' (Polit and Hungler 1985 p.200).

According to Ziebland and Wright (1997 p.110):

'The aim of in-depth interviewing is to elicit the interviewee's perspective, rather than that imposed by the researcher'.

However, out of the 115-page report (Mental Health Foundation 2000) only four pages were eventually devoted to religious and spiritual beliefs. This deficiency was remedied when they provided advisors and trainers for and sponsored research into the subject recently (Mental Health Foundation 2002). Their 27 interviews produced a mixed response, so far as a direct interaction between mental health and religion was concerned, ranging from 'God has become my everything' to 'I have actually said to God, why didn't you just leave me...it was more comfortable when I didn't know'.

The chosen instrument for the current study in Northumberland is the in-depth interview tested on an independent panel of three before use. Of the three, who were not associated with the mental health user group described below, two suffered from schizophrenia and one from schizoaffective disorder. As a result of the testing, some changes were made to the Proposed Interview Questions (Appendix 5). It was found that rigid adherence to the structured interview questions caused the interview to seem rather artificial. To make the interviewee more relaxed, and therefore more forthcoming, questions were modified as necessary to give a natural flow (see for example Appendix 6). The instrument worked satisfactorily otherwise.

## **Sampling**

In the Mental Health Foundation's second phase of research (Mental Health Foundation 2000) 71 people were recruited from 15 mental health service user groups around the UK. Certain characteristics were used to ensure a purposive sample including a 50/50 gender mix and 15 people from ethnic minorities. Two key requirements were to include people both with severe mental health problems and with personal experience of the three areas under examination including religious and spiritual beliefs.

This purposive sampling is criticised as subjective and providing no external, objective method for assessing the typicalness of the selected subjects (Polit and Hungler 1985 p.165). However Hurst (2002) provides a more reasonable view when he observes that quantitative research uses large numbers drawn randomly, whereas for qualitative work he sees smaller samples being used including deliberately selected

cases. By definition of the purpose of the present study those people included must be suffering from a range of chronic mental disorders but it would be more relevant if the sample was randomised for religious experience or affiliation. In this study it is achieved by drawing from a local mental health user group, as did the Mental Health Foundation (2000), and asking the group Coordinator, whose religious position is quite neutral, to make the selection. Fifteen volunteers were selected.

### **Data Generation**

The local mental health group (Contact) made an office available for the interviews. Each volunteer had been given a copy of an information leaflet about the study and had signed a consent form. The information leaflet was discussed before the start of each interview to ensure the volunteer was fully aware. Each interview was semi-structured and based on prepared questions, which each volunteer had seen. A tape recorder was used during each interview and a transcription made afterwards

### **Data Analysis**

The transcript of each interview was subjected to an analysis, reducing each one to its constituent elements. These included relevant personal statistics, clinical diagnosis, coping strategies, and religious orientation and characteristics.

The interviewees said they suffered from a range of mental disorders: schizophrenia (4), manic depression (bipolar disorder) (5), alcoholic paranoid depression (1), anxiety (1), depression (2), grand mal epilepsy with depression (1), and anxiety/depression (1).

Their ages ranged from 34 to 66 but none was in work. 8 interviewees were female and 7 male.

- Means of coping with their illness (other than religion) were listed as:
- taking medication (4)
- partner's support (2)
- clergy visits (1)
- hobbies (3)
- housework (1)
- caring for the children and grandchildren (3)
- study (1)
- understanding the illness and treatment (1)
- support groups (8)
- hospital (2)
- family support (4)
- friends (2)
- social worker (1)

Interviewees' religiousness varied from never religious (2) to 'a way of life' (1). With some it was limited to when they were children (3). 10 regarded their religion as important.

Religious practices of those to whom religion was important included prayer (7) singing hymns (1) bible reading (3) church attendance (2). One of those to whom religion was not important said that being in a church building made her feel safe so that 'nothing can go wrong'.

Of the 10 who regarded religion as important, 9 said it was their main way of coping. One knew her religion was important but said it had an adverse effect on her mental health.

Not one interviewee claimed that s/he had ever been asked by a health professional about religious issues. Most (13) would have been happy if they had been, 12 of whom thought that professionals should ask about it because it could help. Only one would have objected to it.

Most (11) did not feel that variation in their mental health had had an effect upon their religion. Some (4), however, felt it had adversely affected their religious faith and practice.

Most did not believe that anyone else's religion had affected their mental health but some (2) had been adversely affected whilst others (4) had been helped by the religion of others.

## **Findings and discussion**

### **Synthesis**

From the above analysis it is now possible to synthesise the findings from the research done with this small group of 15 interviewees.

There was no discernible link found between religiousness and psychotic illness. Those claiming religion to be unimportant included one suffering from schizophrenia, one from bipolar disorder, one from depression, one from grand mal epilepsy with depression, and one from anxiety/depression. This left the religious group suffering from schizophrenia (3), bipolar disorder (4), alcoholic paranoid depression (1), anxiety (1), and depression (1).

There was no apparent link between interviewees' gender and their religion or irreligion: the irreligious group were composed of three men and two women. This group were also of mixed ages; two were grandparents and three younger.

Church attendance was not an emerging theme. Only two of the religious group seemed to gain help from going to church and one man felt guilty for non-attendance. This may have been because each one found social support in the mental health group.

It was, however, possible to discern clear themes from those of the religious group:

### **Theme 1**

'When you feel at a low ebb, the first thing you do is pray.'

'I pray all the time and more so when I am low'.

Prayer to God was central to this group. This prayer, however, was purely individual and expressed a personal reliance on God. Feelings of the nearness of God varied, sometimes with mood, but to believe he was available was important and this was a main means of promoting mental health.

### **Theme 2**

'I walk hand in hand with God'.

'I felt I had a second chance, I felt that someone was looking after me'.

The concept of being on a journey with God was important. Even if prayer was difficult the sense of his presence was valued. The companionship, through mental illness, of someone each called 'God' was valued and seemed integral to health.

### **Theme 3**

'My faith goes on just the same, even though a bit ragged, when I'm ill'.

A personal faith was important for all in the group. This was not expressed in any stereotypical way. Sometimes it was the result of an experience:

'Having that experience I couldn't doubt God at all, but when I was going through terrible experiences...I wondered what it was all about'.

This faith or trust in God was something intrinsic to each interviewee of the religious group and seemed vital to their psychic survival.

### **Theme 4**

'I have a God... and a warm, loving God'.

'It's possible to be ill even with faith in God but there's always hope and love'.

This was the kind of God experienced generally by the group even though they had all suffered greatly in their lives. Interviewees did not blame God for their illness but depended on a relationship with her/him to experience a deep, healing love.

### **Theme 5**

'I occasionally have a little chat. I just ask him for simple things and remember to thank him afterwards. It's that leper story isn't it?'

'My belief in God has helped in every way all the time'.

The quality of the faith of this group is represented by these quotes. It is never deeply theological but very practical. It is profound but accessible. Interviewees in this group expected God to help and claimed to receive this help.

### **Theme 6**

'I don't normally discuss religion – I find it a very private thing'.

'There is a lot of stigma about religion'.

From discussion before and during the interviews it appeared that none of the group would normally talk about their religious faith or practice, not even to their partner. The Coordinator of the mental health group had, however, experienced no difficulty in recruiting volunteers and each one of the religious group seemed eager to tell their story of faith at interview. For members of this group their religion was intensely personal and, whilst effective for them, the experience was not to be shared with others under normal circumstances. Since the interviewees were all part of the local mental health group which incorporated a self-help group, it would be useful to explore if interviewees being more open about their religiousness could help others of the group. It would also have been interesting if time had permitted to have set up a focus group of the interviewees to see how open interviewees would have been with each other.

### **Theme 7**

All answered the question of health professionals asking patients about their religiousness with some hesitation although all had received a copy of the list of questions. It could be significant that the non-religious group were least hesitant and



generally thought this enquiry should be made. Of the religious group, three thought they would be happy about it, three would not be happy, and four were not sure. Comments varied from:

'I don't think it would help if they asked me about this subject'.

to a positive:

'It would have helped to get to know the person from a religious point of view. It could have helped with treatment'.

One person reported a bad experience:

'I do remember the social worker I have at the moment said 'It's a load of rubbish', so I don't mention it to anyone now. It is such a fundamental thing to people – the soul and heart of people'.

This uncertain reaction could be seen as a continuation of Theme 6, but was probably something different, since all had agreed to be interviewed about religious matters by someone they recognised as a health professional. The interviewees were happy to talk about their religion as a separate exercise but not so keen to talk in a clinical setting.

## **Conclusions and recommendations**

### **Main Findings**

Both the literature review and the qualitative study demonstrated a strong correlation between the religiousness of people with mental disorders and their mental health. However, it seemed necessary for a definite commitment to religious faith to be present before any positive effect on mental health was seen. This had to be evidenced by the presence of associated religious practices involving rather more than attendance at a place of worship. This would have been expressed by Allport and Ross (1967) as intrinsic religion. It was difficult to see a causal relationship proven in the literature but this small qualitative study does provide more evidence of this and underline the need for a comprehensive U.K. study.

Neither the literature nor this qualitative study gave evidence of the mental health of persons being significantly influenced by the religion of others.

There was some evidence of the religion of those suffering from a mental disorder being adversely affected by their illness but this effect appeared transient.

It can be seen from the literature reviewed that there is a powerful move in the USA. to include aspects of religion or spirituality in the curriculum of the training of health professionals. There is some evidence of this desire reaching the UK. This is a positive move if it will encourage professionals to view patients more as persons who have a spiritual component to their lives (Barham and Haywood 1991 p.117-120). The evidence shows, however, that professionals have to think through the ethics of discussing this dimension with patients and make sure this is acceptable within the professional/client relationship. However, since this dimension can be so important to some patients, their clinical diagnosis and successful treatment may suffer if it is ignored by a health professional.

## **Recommendations for service providers**

### **Professionals**

Health professionals should not discuss religious issues in depth with their clients unless the professional a) has had training in the area or b) has a personal interest in the area and c) is confident that such discussion will not compromise professional ethics. The foregoing recommendation does not preclude preliminary discussion before seeking client approval for referral to a professional with suitable training and/or experience. If a patient is found to have an interest in religious issues health professionals may encourage the interest providing it is not demonstrably detrimental to health outcomes. If a chaplain experienced and/or trained in mental health is available the patient should be asked if a referral is desired.

Clinicians should consider suggesting a referral of an outpatient to such a mental health chaplain if they feel that their patient may either have a religious component to her/his illness or is using religious beliefs or practices as coping mechanisms.

Chaplains working in the mental health area should undergo suitable training in mental health in addition to any general healthcare training undertaken.

### **Trainers**

Aspects of religion and spirituality should be included in the curriculum of the training of health professionals. This is not to produce religious experts but to facilitate an understanding of spiritual concepts in the lives of their clients.

### **Managers**

As part of their audit of the standards of care in hospital (NHS 2001 p.28 – 31) managers need to include in the audit sensitivity to, and respect for, religious, spiritual and cultural needs of patients. As well as asking about religious affiliation, if any, patients should be allowed time and opportunity to discuss their religiousness or spirituality should they wish. This opportunity should not be just on admission but should be a continuing opportunity to allow for the difficulty, demonstrated in this study, which some will experience in articulating their needs and orientation.

### **Conclusion**

The study has shown a substantive relationship between mental health and religion. This has not been through the use of a randomised, controlled trial but through qualitative research. It should be emphasised that this is evidence that is admissible and should be acceptable by the NHS as a contribution towards evidence based practice.

In this context a U.K. wide qualitative study is recommended focusing solely on this relationship. As in this study it would be useful if sampling could be randomised for religiousness and the non-religious group used as a control.

In the present study the clinical self-assessment of each interviewee has been relied on throughout. This is totally subjective, depending on how the individual estimates her/his mental state. To increase objectivity clinical assessment of interviewees by health professionals is recommended, for example using rating scales to measure the severity of depression. This would be for both the 'control' (non-religious) group and the 'treatment' (religious) group, thus giving a more substantial evidence base.

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