Religious conversion among high security hospital patients: A qualitative analysis of patients' accounts and experiences on changing faith

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Research has shown the importance of religion in recovery from mental illness. Previous studies have investigated why individuals change faith during custody in prison, but there has been no research to date on religious conversion in forensic-psychiatric hospitals. The aim of this study was to understand the experience of religious conversion among patients detained in a UK secure hospital. Thirteen patients who had converted their religion were interviewed and the resultant data were analysed using thematic analysis. Three superordinate themes ('reasons for changing faith', 'benefits of having a new faith' and 'difficulties with practising a faith'), incorporating eight subordinate themes, emerged. Understanding patients' reasons for religious conversion is important for the treatment and support not merely of these individuals, but more broadly with patients in forensic psychiatric care.

Introduction

Despite its decreased importance in most Western societies, religion remains an important part of the lives of a significant proportion of people. Research pertaining to the effects of religion among the general population typically demonstrates that religion has a positive effect on quality of life. Although the attribution of causation is complex, religious involvement has been associated with reduced crime rates (Baier & Wright, 2001), increased ability to cope with distress (Heilman & Witzkum, 2000), improved self-image (Bhugra, 2002), enhanced mood (Hicks & King, 2008), lower levels of depressive symptoms (Idler, 1987), lower rates of suicide and self-harm (Mellor & Freeborn, 2011) and increased life expectancy (Litwin, 2007). Why religion has these positive effects is not fully understood, but some researchers have suggested that the interplay between religious beliefs and the construction of meaning in one's life might play an important role (Fletcher, 2004). In addition, religion might act as a deterrent for behaviours that could have negative effects on health and wellbeing (Fletcher & Kumar, 2014), e.g. sexually risky behaviour (Behere et al., 2013) or substance abuse (Michalak et al., 2007). One of the explanations for the benefits of religion is the social support that may be provided, and the community aspects of being part of a religious group. For example, research by Lim and Putnam (2010) suggested that religious people were more satisfied with their lives as a consequence of the social networks they built within their religious congregations.

Given these positive associations, religion might be of particular significance to those struggling with poor health, including mental disorders. Koenig (2008) suggested that religious affiliation might be pivotal in patients' recovery as it can provide the necessary tools to cope with illness and negative life circumstances. However, not all research has demonstrated such positive effects; some researchers have described increased depressive symptoms in patients with religious affiliation or strong religious beliefs, conceivably due to

feelings of guilt for indulging in behaviours identified as immoral (Azorin et al., 2013). Others have postulated that reliance on higher powers might act as a barrier to engaging in treatment offered by mental health professionals (Touchet et al., 2012). Potential difficulties in differentiating between normal religious convictions and pathological delusional beliefs (Pierre, 2001) add to these complexities and may contribute to the reluctance of psychiatrists to engage with the religious beliefs of their patients (Chidarikire, 2012).

As with studies in psychiatric hospitals, research in prisons has produced conflicting results. In a review of research on mental health and religion during imprisonment, Eytan (2011) reported that religious beliefs were associated with lower levels of violence, fewer arguments and disciplinary sanctions. Stringer (2009) postulated that religion helped imprisoned mothers to cope with separation from their children, whilst a study in a Canadian secure forensic psychiatric centre indicated that religious individuals had lower levels of depression and anxiety, and higher levels of satisfaction with life (Mela, Marcoux, Baetz, Griffin, Angelski, & Deqiang, 2008). Alternatively, other studies have delineated the potentially criminogenic effects of religion in contributing to distorted thinking which may serve both to facilitate the commission of violence, whilst inhibiting responsibility taking by offenders (Knabb et al., 2012). Certainly, the differing role of, and attitude to, religion in countries and cultures should always be considered in the interpretation of such findings, as well as the current societal context. Interpretations of the religion (including religious extremism) will impact upon actual and perceived benefits/disadvantages of identification with a particular religion.

Imprisonment in both mental health and criminal justice settings (and the long periods of time available for introspection by patient-prisoners) might result in a search for meaning in one's life generally, and consequently an increased interest in religion. It may also trigger

the desire for a new identity. Indeed a study of offenders detained in a high secure hospital in the UK (Völlm et al., 2006) reported that approximately 20% of patients had changed their name during their detention, with participants stating that their stay had allowed them to reflect on their lives, and their desire to change their name was partly to denote a new phase in their lives. Some participants also reported a crisis of identity, as they struggled to reconcile their self-identity with their past actions, whilst for others the change of name appeared to be related to psychopathology, namely delusional beliefs. For some patients, name change was also associated with a change in religion, and this had a substantive impact across many areas of their life; change of religion, appeared to denote a major re-orientation in people's lives. This study seeks to examine the phenomenon of religious conversion in a forensic-psychiatric setting.

Empirical research into religious conversion among the general population has demonstrated that it can be associated with a change in personality (Halama & Lacna, 2011), a desire for a new start (Rambo, 1993), liberation from entrapment in personal problems (Kox et al., 1991), the search for support (Fiala et al., 2002), parental divorce (Lawton & Bures, 2001), psychological stress and socialisation (Heirich, 1977), as well as anxiety and insecurity (Kirkpatrick, 1997). In mentally disordered individuals, research has explored the involvement of delusions in religious conversion (Bhugra, 2002). Two studies of change of religious faith looked at the phenomenon of conversion in prison, one UK study (Spalek & El-Hassan, 2006) focused on conversion to Islam and one commissioned by the US Department of Justice (Hamm, 2007) focused on terrorist recruitment in prisons and non-traditional faith groups. Both studies sought to understand the background to religious conversion, and the potential benefits for individuals. Spalek and El-Hassan (2006) demonstrated conversion was influenced by religious experiences in childhood and that a key benefit was that it provided prisoners with a new identity. Hamm (2007) asserted that a

personal crisis, the need for protection and spiritual searching, were key motivators for religious conversion.

Maruna et al. (2006) explored the putative benefits of religion for prisoners and demonstrated that religious identity could be a replacement identity for the negative labels offenders may feel represents their 'master status' (Becker, 2008). Religion also maximised chances of forgiveness, which subsequently had a positive impact on self-worth. However, no such research has, to the authors' knowledge, been conducted in mentally disordered offenders detained in secure forensic-psychiatric settings.

The aim of this study was to explore, and gain a deeper understanding of, the experience of religious conversion among patients detained in a high secure hospital in the UK through analysis of patient-participants' personal accounts of changing their religion.

Method

Participants

The potential sample pool was 330 patients in the hospital at the time of the study, 9.1% of whom had changed their faith. The sample in this study comprised thirteen adult males, ranging in age from 26 to 49 (M = 37.8 years, SD = 7.0 years). All participants were in-patients at a UK high secure forensic-psychiatric hospital. The sample comprised individuals who had changed their faith during their current hospital admission. Initially, thirty eligible patients were identified for the study but seventeen participants were excluded for clinical or practical reasons or opted out of the research.

All participants had a history of serious violent offences, including homicide/attempted homicide (two individuals), and/or serious sexual offences (eight individuals); for two their primary diagnosis was schizophrenia, for ten personality disorder

and for one individual, learning disability.

Materials

The materials comprised an interview schedule, developed using recognised religious/spiritual assessments, namely the Brief Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research (Fetzer Institute/National Institute on Aging Working Group, 1999) and the Religious and Spiritual History Questionnaire (Lukoff & Lu, 1999). The final schedule comprised 40 questions covering: religious background and beliefs; spiritual meaning, values and experiences; prayer experiences and religion/spirituality in therapy, the timing of patients' change of faith, reason(s) for changing faith, any difficulties experienced as a result of their change of faith, the reaction of others, whether the patient thought that their religion helped them and whether their religious needs were being met currently.

Ethical considerations

The study was reviewed and given ethical approval by the National Research Ethics Service Committee and a UK University.

Procedure

The clinician responsible for each potential participant was asked for agreement to approach their patient. With this consent, potential participants were given information about the research. Participants were interviewed individually by the first author in a private hospital room.

Interviews lasted between 30 and 60 minutes. Demographic information, psychiatric and

offending histories and information regarding religious affiliation and change of faith were collected from patients' files.

All interviews were recorded, transcribed verbatim and analysed using thematic analysis. We adopted techniques outlined by Miles and Huberman (1994) and Braun and Clarke (2006) utilising a stepwise approach entailing the thorough reading of transcripts multiple times to increase familiarisation and initial data reduction. Data were organised systematically and themes were identified and reviewed; the second and third authors assessed the robustness of the emergent themes and interpretation of the data to assess the validity of findings.

Results and Discussion

Over half of the participants (54%) had formally changed their religion, the remainder informally (see table 1 for participants' changes of faith). Eight participants (62%) also changed their name.

Themes

Analysis identified three superordinate and eight subordinate themes (see Table 2).

Superordinate Theme 1: Reasons for changing faith

Finding the right fit. Participants' experience of their spiritual journeys was unanimous in terms of identity finding; however, participants' experience of this process differed. For participant three, seeking a faith that he could relate to was important, allowing him to become fully engrossed with that religion:

> 'With me, religion is not about having a religion; it's about relating to it and putting your mind, body and soul into it...' (P3)

For participant eight, feeling at ease with a particular faith was most engaging:

'...out of all the religions I have followed Paganism is one that I feel relaxed with...'(P8)

Finding the right fit was experienced as a never ending process.. There was some uncertainty about how to follow a particular religion as if there were rules that should be adhered to but that were difficult to grasp:

'...I wanted to follow that religion but I didn't know how to...I still haven't found the answer and I think I will be searching all my life for the answer...'(P3)

Finding the right fit provided an opportunity to select aspects of different faiths, implementing the most appealing aspects into one's life to create a new being. For participant three, the practices within Buddhism were particularly appealing; meditation being the fundamental attraction due to its rewarding after-effects on well-being. This notion is supported by previous research that has explored reasons why men are drawn to Buddhism (Lomas et al, 2014). Interestingly, despite declaring loyalty to their current faith, the old faith also provided participant three with a high level of satisfaction. Practicing both faiths facilitated self-growth:

'...I will always be catholic but what I am doing is taking other parts from other religions and using them in my life because the one that I chose (Buddhism) is a religion but it's more like a way of life, so it's like to keep some things like meditation and stuff like that out of Buddhism and applying it to my life... I am just taking something out of that religion... It's about what I can take from those religions and using them to be a better person.' (P3)

However, there was an uncertainty about whether one's chosen faith was the right

one, which prompted self-questioning for clarification:

> "...I question myself. Am I following the right religion? Am I going in the right
>
> path?"(P3)

Changing faith was an inevitable decision when the ethos of the old faith conflicted with sexuality. Disappointment with how the old faith viewed homosexuality and feelings of rejection forced participant eight to search for a faith that fitted with his identity as a homosexual man, replacing feelings of rejection with acceptance. There was an expectation for religion to be tolerant of diversity. However, once he learnt that homosexuality was frowned upon he deviated from that faith. Conflicting perceptions of this kind could evoke what Festinger (1969) termed cognitive dissonance, which could have caused distress to the patient. His decision to change faiths was a response to the feelings felt by a member of the 'out-group'. Religious intergroup (Johnson et al., 2012) describes the tendency for religious groups to form negative attitudes towards the out-group because of their perceived violationsof behaviour.

> '...I am gay and they tend to disagree with people who are gay and I think that is
>
> wrong because if you are religious and you believe in God and Jesus and He is here to
>
> save everyone it is wrong to turn around to someone as a Christian and say sorry you
>
> cannot be in this Christian religion because you are gay...I feel more accepted by
>
> Paganism because Paganism has nothing against homosexuality...' (P8)

There was a desire to find the faith that aligned with individuals' conception of how they should express their faith (privately versus publicly). This was possibly correlated with an introverted personality in one patient:

> '...I consider my faith a very personal thing, you know, but sometimes I find other

faiths more out there...Paganism is a very private thing really... (P11)'

Negative life events. Unexpected negative life events elicited religious conversion for some patients. For participant five, the death of his parents motivated conversion. Their deaths lead to a desire to practise the same faith as his parents. This was his personal way of expressing his love for them. His grievance triggered a sudden realisation about his old faith that shattered his religious worldview. He realised that his old faith was not beneficial for his bereavement because of the perceived positive reference to death:

> 'After my parents passed away, because I wanted to show my love and support to my parents, I asked if I could change my faith back to Church of England...when I lost my parents I thought it was difficult how the Qur'an celebrates it (death) as if it is a good thing.'(P5)

Research has demonstrated that religion is positively associated with the capacity to cognitively process, and to find meaning in, death (McIntosh et al., 1993). For this participant, it appears that, despite a painful bereavement that may cause one to question the existence of God, he did not abandon religion completely. Instead, he readjusted his beliefs to fit with the circumstances. This readjustment led to the return to a previous religion, and subsequently a reconnection to his parents, which helped the participant cope with his loss. This link between religion, bereavement and 'posttraumatic growth' has previously been identified (Currier et al., 2013). Participant six changed faith following a suicide attempt. This was a turning point for his religious journey and he promulgated that his new religion saved his life.

> '...I became a Buddhist through a very serious suicide attempt many moons ago which allowed me to find peace...it stopped me from taking my own life...it took away that need to not be around anymore...I think that without Buddhism I would be dead or

worse...'(P6)

The putative role of religion as a protective factor against suicide or self-harm is certainly worthy of further research.

Changing faith out of respect for others. The support and compassion projected by religious leaders proved to have a significant influence on patients' religious journey because it led to trusting relationships developing, which in turn encouraged, or perhaps catalysed, a change of faith. Participants described how the help they received created a level of respect to the extent of changing their faith to that of the helper; this was their way of showing their appreciation. Patients believed that by changing religion they were giving something back to those who helped them:

> '...The only person I could really turn to at that moment was the chaplain and that chaplain helped me out so I thought to be respectful to him I'll keep going to the services...I got more into it and when I got more into it I thought: Well, why not?' (P10)

For participant nine, the help offered by a religious companion who disagreed with his old faith influenced his decision to convert:

> '...My best friend is a practising Catholic. He is very happy that I have moved away from Paganism.'(P9)

It could be hypothesised that the decision to change faith was not just out of respect; alternative explanations have been offered for the kind of influence identified here, referred to in the literature as 'spiritual modelling' (e.g. Oman et al, 2012). This suggests that the reason for someone to adopt another person's faith derives from what they have learnt and observed in those exemplars of spiritual life. Witnessing the desirable behaviours in others

(e.g. compassion and forgiveness) could have encouraged a wish to follow their example. In the case of religious conversion, individual may seek to join the 'ingroup' (that of his 'best friend'), which brings all the social advantages outlined by Tajfel and Turner (1979).

Superordinate Theme 2: Benefits of having a new faith

Promotion of prosocial behaviour. There was unanimity in participants' accounts regarding the positive behavioural after-effects following changing faith. Adopting a new faith helped stabilise negative emotions, which in turn prevented involvement in antisocial behaviour. Participant nine reported that medication alone was not enough to promote prosocial behaviour; religion for him was the other ingredient required to achieve this:

> 'Medication only helps so much but I haven't been aggressive or anything like that. I try and live a life where I don't harm anybody...' (P9)

These findings support those of Kerley, Matthews and Blanchard (2005) who found a link between religiosity and the reduction of verbal/physical altercations among prisoners. It seems that, for mentally disordered patients, the effects of religion in a high secure setting are not that dissimilar.

Religion in this high secure setting appeared to have served a number of rehabilitative functions; patients reported emotional benefits subsequent to changing faith. Such benefits included feelings of peace and solitude, calmness, mood enhancement, motivation and an escape from troubling emotions:

> '...I've basically gone to Church because to me it's a place I go off the ward where I find solitude and peace and I can just reflect and enjoy the atmosphere...' (P13)

> '...It makes me happy, it makes me want to get up and socialise with people and get to

know people and find out new things and explore the world...it motivates me.'(P3)

'...Buddhism allowed me to escape...it allowed me to calm the mind. It allowed me to function and not be overwhelmed by ruminations, nightmares, flashbacks. It took away that need to not want to be around anymore.' (P6)

These findings coincide with studies conducted in the general population which found positive effects of religion on mood and general well-being (Fletcher, 2004), highlighting similarities between the general population and forensic population in terms of the function of religion in one's life.;

Participant 11 reported that elements of his past religions positively affected his reaction to situations by repressing feelings of anger:

'...Violence is the last thing on my mind now....I've got Buddhism to thank for that as well. It was Buddhism that stopped me from thinking violently, like not wanting to be violent' (P11)

For participant four, faith inhibited the temptation to engage in negative behaviour:

'...I'm much more tolerant and more helpful to people...before I'd fall out with somebody and that might split into a fight...I have to step back, you know...and that peace, that peace comes from my religion...'(P4)

Participant three alluded to how religious morals can be the driving force for prosocial behaviour:

'...how like to treat people and how to respect people and to respect your elders and stuff like that. To be nice to your neighbour and stuff like that...I have become a better person through religion in the way of like crime and fighting and stuff. I am not as

dangerous as I used to be.' (P3)

The positive influence of faith on behaviour can be explained by older theories of antisocial behaviour such as the social control theory (Hirschi, 1969), which contends that the bonds that people create with prosocial values and prosocial people is enough to prevent such behaviour. One type of social bond identified by Hirschi is 'belief'. The proposal is that meaningful values reduce the likelihood to indulge in delinquent behaviour; thus, for someone who holds strong religious beliefs, with a willingness to act accordingly, their behaviour is likely to be controlled by religious-based attitudes rather than antisocial ones.

Faith as a coping mechanism. Participants reported on how their new faith helped with the management of uncontrollable and overwhelming negative feelings. For participant six, the positive feelings provided by their faith substituted negative feelings that had been formed by past traumatic experiences:

'...'I think that Buddhism, in many ways, can keep you calm and, erm...the only problem with these places is when they delve into childhood and they delve into traumas, it's very difficult to keep a lid on it because it can be overwhelming...'(P6)

Escapism was used as a form of coping, which helped manage suicidal thoughts:

'...Buddhism allowed me to escape...I suffer from post-traumatic stress disorder, it allowed me to calm the mind. It allowed me to function and not be overwhelmed by ruminations, nightmares, flashbacks. It took away that need to not be around anymore.' (P6)

Pargament and Bryant's (1998) suggested that it was only by having a religion one could withstand the unbearable situations that come with life because religion helped people to find meaning in a traumatic situation.

For participant 10, diversion techniques used in his faith helped him cope with his problems:

'...If I have had a bit of a crap day or I have had really, really bad problems with certain people...that has helped me when I use my diversion techniques....that is the only coping mechanism that I have got on that day...'(P10)

Trusting in faith for one's destiny. The reliance that participants had on their faith to determine their future proved to be a salient theme. This positive belief in providence relieved feelings of anxiety. 'Handing over control 'to a higher power lifted participants' burdens, making them feel more at ease. Participant four recognised that his situation was unchangeable and so by coming to terms with this reality, with the help of his faith, made the time spent in high secure care bearable:

'...there are things that are out of my control and to worry about them is just stress. I just said I put my faith in Allah and whatever Allah has in store for me will happen and just take comfort from that I suppose.'(P4)

It is unsurprising that patients were preoccupied by life after discharge from hospital. Participant one believed that Allah would determine the timing of his release thereby freeing him of the need to make attempts to be released himself. Inevitably, this restored a sense of hope and provided comfort for this patient, and helped him to cope with his present situation. Clarke (2003) highlighted the concept of faith and hope in relation to what it might mean in the context of feelings of hopelessness. He argued that patients' use of such concepts in their discourse is merely recognition that there are many uncertainties in life; a reality that psychiatrists need to pay attention to in their conversations with patients in order to help them to remain hopeful about their recovery.

'...He knows how I got here, He knows when to release me, He knows when to bring me back into the community...I tend to, in my faith, rely on Allah in those respects.' (P1)

For participant four, not having a release date caused frustration; however, the reliance he had on his faith provided optimism:

'...I haven't got a release date...so that was frustrating, with my frustration came anger and resentment but then again it just teaches me to be patient and put my faith in God really and He will sort it out, you know, when He's ready.'(P4)

Participant 10 expressed the challenged he could face in the community following discharge. However, he trusted that his faith would act as a protective factor:

'...It is going to be very hard for me when I get out, so I am hoping that I am going to be able to put some of them paganism things that have helped me in here into practice when I get out.' (P10)

By relying on their faith there was vision for a crime-free future:

'...It has given me a positive outlook for the future...erm, that I am not going to end up back in this situation again, you know, that I can actually move forward.'(P9)

Superordinate Theme 3: Difficulties with practising a faith

Adverse effects of having a faith. One issue reported by patients was the adverse effects associated with practising a faith. For participant nine, these adverse effects influenced a change of faith. He elucidated the detrimental effects that his old faith had on his mental health; practices within a particular religion combined with episodes of psychosis proved to be a damaging concoction. A problematic effect of religion in psychosis has been reported

before (Gearing et al, 2011), something that Wilson (1998) postulated was due to disordered thinking leading to unusual interpretations of religious matters. It was an interesting observation that, although religion was a precipitating factor to the etiology of this patient's previous problems, another religion significantly reduced these problems:

> '...I am prone to lapse into psychosis...some of the things in paganism are not good for that, you know, so I think that the more that I have come away from it the better I have got....I got a real sense of foreboding that I was doing the wrong thing, that I was being influenced by the wrong things...and I had to do something about that...now before it was too late...' (P9)

The feeling of guilt emerged from participants' religious journey, which appeared to evoke two responses: feelings of unworthiness and a need for forgiveness. Participant nine expressed that feeling unworthy caused him to refuse atonement:

> '...I won't take communion and the reason why I won't do it is because I don't feel worthy. I don't feel worthy enough to do it.'(P9)

Participant three explained how negative feelings intensified the need to pray for forgiveness, and that concerns about how he could be perceived induced a desire not to be judged for his actions:

> 'I pray for strength and forgiveness and, you know, I say sorry to God. I say that I am not worthy and I want to be worthy. Don't judge me for the bad things I have done, just judge me as a person.'(P3)

These experiences of our interviewee are related to what Maruna et al. (2006, p.174) described as a form of 'shame management'.

Lack of resources and lack of support for 'minority' faiths. Being refused access to items perceived to be important for religious expression was a fundamental problem for participants. There was an air of frustration with the limited amount of information that they had access to, which participant 11 attributed an inability to practise his new faith to its entirety:

> 'I am very restricted as to how I can get that information, so it's quite disappointing really...It's quite frustrating because I'm sure my faith could be open to me more if I knew more, if I understood more. The minute that I'm out I'm getting books from the library to get what I can' (P11)

Participant six expressed his annoyance with the security constraints within the hospital forming a barrier to practising his faith due to the inaccessibility of religious equipment. Participants appeared unconcerned regarding the potential risk associated with particular items; instead, participants took the refusal personally, interpreting it as a lack of respect:

> '...Joss sticks. Things here that they won't let you have even though it is part of a belief, religious process.'(P6)

This experience contrasts to that of another participant who described how the process for access to religious resources was straightforward:

'...as far as I'm aware anything religious that I've requested has never been knocked back, the hospital had no problem...' (P12)

It was evident that the heterogeneity in access to religious resources for different religious groups generated competitive attitudes. Participants were envious of those who frequently acquired new resources with ease, which exacerbated the urge to acquire new

equipment for themselves.

For participant three, being a member of a 'minority' faith was problematic. He described how some religions were dismissed by chaplaincy. Faith change was instigated by the perception that other faiths were more accommodated for:

'...you might get a lot of people who are interested in certain religions. Christianity is a popular one but Buddhism is not very popular so you can't do a service all the time...Buddhism is as important as any other religion...'(P3)

Limitations

There are a number of limitations to this study. First, approximately one third of eligible participants did not wish to participate in this study; whilst this is relatively low, it nonetheless highlights a potential skew in the type of participant (and their religious experiences) consenting to the research. Furthermore, our participants represent a unique group of individuals, those deemed a 'grave and immediate danger' to the public based on their mental condition and risk; as such their experiences may not be applicable to patients or offenders in other settings, such as prisons.

Second, all qualitative research faces specific challenges apropos validity and reliability: in order to address these two critical concerns, the following processes were utilised in this research: a transparent process of data collection and analysis using an established method and process, a reliability 'check' of the analyses by co-authors (which included the rereading of all transcripts by the second author), a 'time out' period from the analysis by the first author (to contribute to a more objective perspective on the data) and a reading 'check' by the hospital chaplains.

A further challenge, which is found in qualitative and quantitative research, is the

experimenter effect, or the truthfulness of participants' responses given the social context under which information is obtained (Brink, 1993). Participants may have been susceptible to experimenter effects since interviews were conducted in the presence of the hospital chaplain and, given the nature of the study (religion based), there may have been pressure to portray their religious experience in a way to please the chaplain – although it should be acknowledged that none of the participants were now of the same religion as the chaplains present at interview. Moreover, it is hoped that the presence of the lead chaplain (who is responsible for ALL faiths) facilitated engagement and improved the richness of the data.

Conclusion

The aim of this study was to explore, and gain a deeper understanding of, the experience of religious conversion among patients detained in a high security hospital through analysis of their personal accounts. It is not uncommon for mental health professionals to dismiss religious aspects in a patient's recovery; we would argue, however, that health care professionals have an obligation to consider religion as a valid contributing factor to a patient's treatment and that exploring such issues with patients can aid their recovery.

The findings presented in this study provide an extended insight into religious conversion and highlight the role of religion in a patient's identity and search for meaning. Religion appears to provide patients with traumatic life histories, residing in a highly restrictive setting for extended periods of time, with a sense of hope and self-worth and may support them in adapting a more prosocial life style. Notably, we could not find any evidence for the anecdotally reported pragmatic or even manipulative change of religion to obtain privileges (such as one-to-one time with chaplains, different foods, additional items) or for a change in religion being motivated by a desire to minimise one's own role in one's offending. Professionals would therefore be well advised to engage in supporting patients in their

religious journeys as part of their recovery process. This may well have other positive effects in terms of engagement and overall progress.

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Appendices

Appendix 1: Table one

Appendix 2: Table two

Table 1. Frequency and type of religious conversion by participants

Patient	Faith on admission	1	2	3	4	5
1	Christian	Muslim				
2	Christian	Muslim				
3	Catholic	Buddhism	Catholic			
4	Christian	Buddhism	Catholic			
5	C of E	Muslim	C of E			
6	C of E	Buddhism	C of E			
7	C of E	Muslim	Buddhism	Muslim		
8	C of E	Catholic	Jewish	Hindu	Wicca/Paganism	Judaism
9	Paganism	Christian				
10	Catholic	Paganism				
11	Christian	Buddhism	Paganism			
12	Catholic	Jehovah's Witness				
13	None	Christian	Atheist			

Note: C of E = Church of England

Table 2. Superordinate and subordinate themes

Reasons for changing faith	Finding the right fit
	Negative life events
	Changing faith out of respect for others
Benefits of having a new faith	Promotion of prosocial behaviour
	Faith as a coping mechanism
	Trusting in faith for one's destiny
Difficulties with practising a faith	Adverse effects of having a faith
	Lack of resources and lack of support for 'minority' faiths