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RELIGIOUS FAITH AND MENTAL HEALTH OUTCOMES

THOMAS G. PLANTE
NAVEEN K. SHARMA

If one were to type in the keywords “religion,” “spirituality,” and “health” on various Internet search engines, one would find an exhaustive list of sites, well into the hundreds. Many of these sites publicize clinics that employ spiritual and religious treatments; church organizations promoting health benefits; institutes that educate individuals on the relationship between religion and health; various international religious and spiritual retreats aimed at promoting health; and videos, books, and publications on this topic. As is evident from a simple Internet search, the impact of religion and spirituality on health has become a hot topic among the general public. However, a similar search specifying “mental health” in place of general health results in a comparably smaller number of sites. Although the relationship between religious faith and mental health outcomes may not be as well known among the general public, it has become an increasingly popular subject of investigation among social scientists and professionals in various fields ranging from clinical psychology, to pastoral psychology social work, anthropology, sociology, and medicine.

Recent research on religious faith and mental health outcomes has generally demonstrated a positive association between the two constructs. This research has led to the integration of religious and/or spiritual issues into

clinical assessment and treatment of a wide range of mental health issues. Considering that 80% of the world's population belongs to one particular religious tradition or another (Bernstein et al., 1995), it is important to pursue a greater understanding of what role, if any, religion and spirituality play both in fostering positive mental health and in facilitating the recovery from mental illness.

In this chapter we review recent research regarding the relationship between religious faith/spirituality and mental health outcomes, as well as provide directions for future research and discussion. The specific aspects of mental health and illness that we focus on include well-being, depression, anxiety, substance abuse, and schizophrenia. We also briefly discuss research pertaining to religious faith and personality disorders, eating disorders, somatoform disorders, and bipolar disorder.

WELL-BEING

Well-being has been defined as a multidimensional construct including morale, satisfaction with life, congruence with expected and achieved life goals, positive and negative affect, mood, symptoms related to distress (Diener, Suh, Lucas, & Smith, 1999; Levin & Taylor, 1998), self-esteem (Wilcock et al., 1998), and prosocial values and behaviors (Donahue & Benson, 1995). Most studies investigating religious involvement and well-being have uncovered a strong association between the two constructs (Koenig, 1995a; Levin, 1997), though there are studies that have shown either a negative association (Wilcock et al., 1998) or no significantly clear positive or negative association (Donahue & Benson, 1995; Pargament & Park, 1996). In a study using the Santa Clara Strength of Religious Faith Questionnaire, for example, Plante and Boccaccini (1997) found that college students with high strength of religious faith had higher self-esteem, hope, and adaptive coping and less interpersonal sensitivity. Positive associations with well-being may be due to the impact of faith on both positive and negative emotions, such as increased forgiveness and reduced guilt, respectively, which may enhance the individual's development (Ellison, 1998). Idler and Kasl (1997) found that ritualistic religious behavior may likewise promote well-being through such behaviors as cathartic worship services.

Evidence suggests that socialization through religious participation in a congregational setting may also promote prosocial and adaptive qualities, elevating mood and decreasing levels of distress (Donahue & Benson, 1995). For example, in the African American community, church attendance and activities have been found to be an effective coping mechanism, promoting well-being (Blaine & Croker, 1995). Many religious institutions function as sources of social support for youth and families. Informational social sup-

port is provided through educating the community on key values and issues ranging from substance abuse and violence prevention to health-compromising behaviors that may influence well-being (Donahue & Benson, 1995). Religious institutions also provide emotional social support by creating a feeling of connectedness for individuals in the congregational community (Blaine & Croker, 1995). Some of the positive effects of religious faith on well-being include increased self-esteem and positive life outlooks, as well as social support networks that may lessen the detrimental effects of stressful life events through religious beliefs, expressions, and support (Koenig, 1995a).

A number of studies have focused on the influence of religion on the well-being of specific populations, such as the elderly, adolescents, and various ethnic groups. These studies have coincided with Levin and Taylor's (1998) view that the relationship between religion and well-being can be accurately estimated only after taking into account such determinants as health, socioeconomic status, age, and ethnicity.

Spirituality has been found to be an integral factor in the African American community. For example, Frame and Williams (1996) termed spirituality the "whole of life" for many African Americans. In a recent study, the well-being components of life purpose and satisfaction were directly related to either or both the individual's relationship with God and an active religious life (Fleming & Anderson, 1998).

In research with adolescents, Varon and Riley (1999) noted that although maternal education, race, type of religion, and frequency of the adolescent's church attendance were not significantly associated with well-being, the social support provided by a mother who attends church at least once a week may be a strong contributor to adolescent well-being. In other investigations among adolescents, religiosity has been found to be a strong inhibitor of maladaptive behaviors that negatively influence well-being (e.g., smoking, alcohol consumption; see Willis, Wallston, & Johnson, Chapter 9, this volume). Religiousness was also observed to be a strong inhibitor of suicide ideation, suicide attempts, alcohol use, and sexual involvement among adolescents, while promoting prosocial behavior, such as volunteer service (Varon & Riley, 1999).

Studies have also examined the relationship between religious coping and well-being. Plante, Saucedo, and Rice (2001) speculated that religious coping might be helpful for individuals experiencing significant trauma but not necessarily for those with moderate daily hassles. They found that religious coping was unrelated to the management of daily hassles among college students. Among caregivers of ill persons, prayer and church attendance emerged as positive coping mechanisms for families of children with disabilities, giving them strength and hope (Bennet, Deluca, & Allen, 1995). Religious coping was also reported as an adaptive coping mechanism among

Salvadoran immigrants migrating to the United States following the civil war in their homeland (Plante, Manuel, Menendez, & Marcotte, 1995).

Selway and Ashman (1998), however, theorized about the possible aversive effects of religion on the well-being of the disabled, recognizing that a number of world religions portray disabled people in a stereotypical and negative manner in many religious texts. In this sense, adherence to these religions may contribute to stigmatization and negatively influence the well-being of church members with disabilities.

To promote well-being, treatment plans have been offered that emphasize the role of spirituality and religiosity in therapy. Richards, Rector, and Tjeltveit (1999) highlighted the value of affirming clients' core spiritual values, exploring how to live congruently with those values, and accessing the spiritual resources in their lives. Increasing spiritual and/or religious integration in psychotherapy has been found to improve treatment outcome for religious clients (Miller & Thoresen, 1999). Addressing religious issues may also help clients become more aware of goal content and goal conflict, which are associated with well-being (Emmons, Cheung, & Tehrani, 1998). Aside from psychotherapy clients, individuals with chronic medical illnesses, such as HIV/AIDS, frequently seek spiritual and religious resources for well-being (O'Neil & Kenny, 1998).

Many studies that have observed a strong positive association between religiosity/spirituality and well-being reflect variables such as the creation of healthy emotionality, structured rituals, and the belief in a life purpose. For many people, participation in religious or spiritual practices in a congregational setting has also been found to enhance feelings of social support and connectedness with a greater community, as well as inhibit maladaptive behavior such as smoking, excessive drinking, and sexual acting out. Religious coping mechanisms such as prayer and church attendance appear to be helpful in maintaining a sense of well-being. Thus far there is less research about the effectiveness of integrating religious and spiritual perspectives into therapy, but preliminary findings have been promising, and this is becoming an active area of inquiry.

DEPRESSION

Recent research on the relationship between religious faith and depression has generally suggested that religiosity is associated with decreasing levels of depression (Catipovic, Ilakovac, Durjancek, & Amidzic, 1995; Cosar, Kocal, Arikan, & Isik, 1997; Plante & Boccaccini, 1997). However, some studies have found no clear association between depression and religious involvement (Koenig et al., 1997). Most studies that examine the relationship between religion and depression fall into three categories: religiosity as

decreasing susceptibility to depression, religion as a coping mechanism for dealing with depression, and the benefits of religious and/or spiritual components in treating depression.

Intrinsic religiosity (religiosity that is based on internal beliefs, such as faith, rather than external benefits, such as social connections) is significantly associated with lower levels of depressive symptoms (Mickley, Carson, & Soeken, 1995; Watson, Milliron, Morris, & Hood, 1994); on the other hand, certain private religious behaviors, such as watching religious television programs and personal prayer, have been found to be positively associated with depression among the elderly (Koenig et al., 1997).

Other studies have focused on "death-depression" (depression related to an increased awareness of the inevitability of death); lower levels of depression were found among individuals who held a belief in some form of an afterlife (Alvarado, Temper, Bresler, & Dobson, 1995). Other studies have noted that depression was less likely among religious individuals with medical illness or religious surgical patients compared with their less religious peers (Richards & Bergin, 2000). Similarly, lower levels of depressive symptoms have been reported among church-attending elderly (Richards & Bergin, 2000), with individuals who attend church being half as likely to be depressed as those who do not (Koenig et al., 1997).

Cross-sectional studies such as these are interesting, but the mixed results are difficult to interpret. It is unclear, for example, whether connections between increased private prayer and increased depressive symptoms (Koenig et al., 1997) mean that greater private religious expression elicits greater distress, that greater distress mobilizes more intensive prayer, or that other unknown variables may be at play. Longitudinal studies, which seek to track these connections over time, are more illuminating. For example, in a 10-year longitudinal study, Miller, Warner, Wickramaratne, and Weissman (1997) found maternal religiosity and maternal-offspring concordance of religiosity to be protective agents against depressive symptoms among their child offspring.

Understanding the role of religion for people of various cultures is integral in appraising the self-assessment and recovery experiences of individuals suffering from depression (Fallot, 1998). Individuals of the same religion around the world have different religious experiences, based on their particular culture. Although Islamic tradition strongly disapproves of suicide, 43% of depressed Muslim women in Turkey repeatedly attempted suicide (Cosar et al., 1997), whereas greater religiosity among Muslim refugees in Afghanistan was associated with lower levels of vulnerability to suicide (Jahangir, ur Rehman, & Jan, 1998). The different cultural contexts of these two Muslim communities may contribute to the dissimilarity of the association between religiosity, depression, and suicide attempts. Similarly, religiosity is associated with low levels of depression and high levels of "happiness"

in the Netherlands (Gopal, 1997), whereas it is associated with high levels of depression in employees in Croatia (Catipovic et al., 1995).

As a coping mechanism, religious faith and religious/spiritual practices function to ease the grieving or bereavement process of many individuals experiencing exceptional circumstances who may be at risk for depression. For example, a number of studies have examined the experience of parents grieving the death of their child. The many coping mechanisms employed by individuals whose children had died of sudden infant death syndrome, neonatal death, or stillbirth, reflect, in part, the religiosity of the parents. Parents who regularly attended church prior to the death of their infant continued to attend church as a means of coping after the death, whereas those who previously did not attend church services were still not inclined to do so. Those individuals who did attend church were less likely to report depressive symptoms than those who did not (Thearle, Vance, Najman, Embelton, & Foster, 1995). Self-directed religious behavior, such as going to church, was found to increase under times of high stress and decrease while bereaved parents were suffering symptoms of depression (Bickel et al., 1998). Religiously informed treatment was found to be effective in enhancing the grieving process of parents mourning the loss of their child (e.g., Livneh, Antonak, & Maron, 1995).

Similarly, religious coping mechanisms and religious appraisals played a key role in susceptibility to depression in caregivers responsible for the care of terminally ill family members (Harrington, Lackey, & Gates, 1996; Kazanigian, 1997; Mickley, Pargament, Brant, & Hipp, 1998; Reese & Brown, 1997). Caregivers who appraised their situation of caring for a terminally ill relative as holding meaning in God's greater plan or as a means of spiritual revelation or introspection were less likely to experience depression, whereas those who felt their situation was punishment from God or was unjust were more likely to be depressed. Mickley, Pargament, Brant, and Hipp (1998) found that caregivers who interpreted their difficult situation in terms of "benevolent religious (or secular) reframing" and "God's will" adapted successfully (i.e., displayed fewer depressive symptoms). Unsuccessful appraisals included "apathetic God," "unfair God," and "unjust world."

Other important groups that have been studied with respect to their use of religious or spiritual coping are the elderly and patients with HIV/AIDS. Among the elderly, religiosity was not associated with the incidence of depression but was strongly associated with the improvement of depression (Braam, Beekman, Deeg, Smith, & Tilburg, 1997). In a study by Koenig, Weiner, Peterson, Meador, and Keefe (1997), 43% of a sample of chronically medically ill elderly patients were diagnosed as clinically depressed, with 60% of these depressed patients utilizing religiosity as a coping mechanism and 34% reporting religion to be the most important factor enabling them to cope. Religion was also the most important coping factor for elderly

federal inmates. For these men, depression was negatively associated with the inmates' intrinsic religiosity and the perceived importance of religion to the inmate, as rated by their primary caretaker in the facility (Koenig, 1995a). In regard to death-depression, the acceptance of death and decrease of death-depression among many elderly were tied to faith and spiritual values (Hinton, 1999). A decrease in death depression was also negatively associated with the belief in a religious or spiritual afterlife (Alvarado et al., 1995).

As a coping mechanism among patients with HIV/AIDS, religion seems to play a similar role for both men and women patients. For HIV-positive gay men, religious coping was significantly associated with lower levels of depressive symptoms, though religious behavior (e.g., church attendance) was not related to depression (Woods, Antoni, Ironson, & Kling, 1999). For women, religious coping, in the form of prayer and rediscovery or redefining oneself, was the most frequently adopted coping response to their illness (Kaplan, Marks, & Mertens, 1997).

The value of attending to religion in psychotherapy to ameliorate depressive symptoms has been replicated in various studies, though it is not evident in all empirical findings (McCullough, 1999). Hood-Morris (1996) proposed a spiritual well-being model for providing holistic treatment for depression in older women. She described holism as "an integrated dynamic, evolutionary, and vital conceptualization of the biological, psychological, social and spiritual aspects of human nature" (p. 440). Though her model emphasizes the use of holism in regard to depressed elderly women, this type of biopsychosociospiritual model is advocated by many other health professionals for assessment and therapy (e.g., Cornet, 1998; Kok & Jongsma, 1998). A multidimensional model such as this is also beneficial in acknowledging the potential role of the pastor as a provider of treatment, along with family and the medical community (Gilbert, 1998). Research has also shown the beneficial effects of religiously oriented treatment with depressed disabled elderly patients (Chang, Noonan, & Tennstedt, 1998), as well as with depressed students (Shapiro, Schwartz, & Bonner, 1998).

Religiousness and spirituality appear to reduce the incidence of depressive symptoms, though religious practices sometimes have been positively associated with depression. Intrinsic religiosity, maternal-offspring concordance of religiosity, and church attendance are a few religious factors that have been shown to reduce the incidence of depression. Religious coping mechanisms such as church attendance and healthy religious appraisals have been helpful to buffer the effects of or reduce the susceptibility to depression among bereaved individuals, caregivers, and the terminally ill. Holistic treatment strategies that integrate religious and spiritual factors into therapy appear to be beneficial for many people suffering from depression.

ANXIETY

Religious faith has been shown to possibly both contribute to (Shooka, Al-Haddad, & Raees, 1998; Trenthold, Trent, & Compton, 1998) and inhibit the incidence of anxiety symptoms (Ita, 1995–1996; Kaplan et al., 1997). Positive mental health outcomes among anxiety patients have been noted among individuals who are intrinsically religious and among individuals who employ religious or spiritual coping mechanisms, as well as among both religious and nonreligious individuals who participate in religion or spirituality-based treatment (Jahangir, 1995). Negative outcomes among anxious persons have been found among individuals who were raised with strict religious upbringings and among religious individuals with obsessive-compulsive disorder (Shooka et al., 1998). In a multiethnic, multireligious sample, the majority of patients with obsessive-compulsive disorder identified themselves with a religious affiliation, but no clear relationship could be found between the type of obsessive-compulsive symptoms and the specific religious affiliations of the patients with obsessive-compulsive disorder (Rapheal, Rani, Bale, & Drummond, 1996).

Research has also shown that panic patients may overemphasize religious concepts such as sin. This overemphasis may lead to hyperbolic feelings of guilt and shame, causing additional panic (Barr, 1995). Trenthold, Trent, and Compton (1998) broaden the definition of panic disorder to include one who “is fraught with anxiety that is fueled by cognitions about her needs for both approval and perfection, someone whose failures are associated with thoughts about blame and punishment, someone who is in conflict about her ability to meet the standards set by her religion which, in turn, is associated with guilt” (p. 63). Specific examples of the moral transgressions and conflict experienced consciously or unconsciously by panic sufferers raised with strict religious upbringings include anger toward God during periods of bereavement and questioning one’s sexuality. Interestingly, religious conflicts regarding moral transgressions are significant predictors of panic disorder but not of other psychological disorders (Trenthold, Trent, & Compton, 1998).

However, as in depression, a normal, healthy religious life appears to be a predictor of positive mental health outcomes and negatively associated with anxiety disorders. Intrinsic religiosity has been associated with low levels of general anxiety in various populations (Lotufo-Neto, 1996; Mickley et al., 1995; Richards & Bergin, 2000) and low levels of death-anxiety when compared with individuals who were extrinsically religious (Clements, 1998; Richards & Bergin, 2000). Intrinsic religiosity was also negatively associated with neurotic guilt (Richards & Bergin, 2000). In a proposed causal path model, Ita (1995–1996) attributed the negative correlation

between age and death-anxiety to the increasing importance of spirituality for individuals throughout the lifespan. Death-anxiety among terminally ill patients with HIV/AIDS was negatively correlated with utilization of religious and spiritual coping mechanisms (Woods et al., 1999), specifically with the use of prayer and self-discovery (Kaplan et al., 1997).

Though most research on the relationship between intrinsic religiosity and anxiety demonstrates an overwhelmingly negative association, research examining this relationship within particular socioreligious contexts suggests important cultural differences. In a cross-cultural study by Tapanya, Nicki, and Jarusawad (1997), intrinsic religiosity among Christian and Buddhist individuals was inversely associated with anxiety. However, extrinsic religiosity was associated with high levels of anxiety for Buddhists but not associated with anxiety for Christians. One possible explanation for this difference is the different notions of the afterlife and means toward enlightenment in these religions. Extrinsic religiosity among Buddhists, theoretically, could hinder a person's path toward enlightenment, which ideally is gained through intrinsic religiosity and inner awareness. For Christianity, extrinsic religiosity would not necessarily prevent a person from attainment of a positive afterlife experience.

Religious and spiritual involvement among people experiencing high levels of stress is significantly associated with lower levels of anxiety (Holtz, 1998). For example, high strength of religious faith was associated with lower anxiety among substance abusers (Plante, Yancey, Sherman, Guertin, & Pardini, 1999). For HIV individuals who were preparing for or experiencing the death of a partner, various personal and traditional religious rites for the spirit and body of the dying helped them cope and obtain closure with the loss of the loved one (T. Richards & Folkman, 1997). Though religious and spiritual coping mechanisms were reported as highly comforting for the bereaved, the experience of spiritual phenomena, such as feeling the presence of the deceased, was related to higher short-term anxiety.

Psychotherapy that integrates issues of religion and spirituality for individuals with an anxiety disorder has been productive for religious individuals (Razali, Hasanah, Aminah, & Subramaniam, 1998). During psychotherapy, therapists may also suggest that a client create a personal sense of religious meaning (or set of spiritual beliefs, if the client is not affiliated with any formal religion) and rituals that may serve as coping mechanisms (T. Richards & Folkman, 1997). For those individuals whose anxiety disorder is assessed to be related to strict religious upbringing, possible directions for therapy may include positive self-talk assignments to counter feelings of guilt and shame (Barr, 1995) and addressing topics of forgiveness of sin and salvation (Trenholm, Trent, & Compton, 1998).

Because religion and spirituality have been both positively and negatively associated with anxiety, further research needs to be conducted to

investigate the nature of the religious or spiritual factors that may influence the incidence and treatment of anxiety. Recent research presents the possibility that the positive association between religion and anxiety occurs among individuals experiencing unusually strict religious upbringings or among individuals with underdeveloped, vague, or overemphasized ideas of religion or spirituality. Research investigating the particular nature of religion and spirituality among anxiety sufferers may shed light on why a positive association exists. At the same time, we cannot dismiss the wealth of research that demonstrates a negative association between religion/spirituality and anxiety among individuals with "healthy" religious and spiritual beliefs and practices.

SUBSTANCE ABUSE

Though some researchers have theorized that a lack of a sense of spirituality may contribute to alcoholism (Warfield & Goldstein, 1996), it is difficult to ascertain whether alcoholism is directly related to the nature of one's spirituality (Chapman, 1996; Wing, Crow, & Thompson, 1995). Many studies have examined the association between religiosity and spirituality and alcoholism and the effectiveness of spiritual interventions in the recovery process. Religion plays a significant role in one's decision to use alcohol (Rajarathinam & Muthusamy, 1996). Intrinsic religiosity is a predictor of low levels of substance use or abuse (Fischer & Richards, 1998), whereas predictors of substance abuse include a feeling of disconnectedness with one's religion (Gillis, & Mubhashar, 1995) and one's specific religious affiliation (Peele, 1997). Likewise, individuals who were substance abusers or users generally have low levels of religious involvement (Miller, 1998).

In a study examining the religious dimensions of personal devotion, personal conservatism, and institutional conservatism, Kendler, Gardner, and Prescott (1996) found religiosity to be significantly and negatively associated with substance abuse and a lifetime history of alcoholism. Though religious beliefs influenced a person's tendency ever to use a substance, one's religious devotion or spirituality influenced one's ability to quit or maintain low levels of substance use (Kendler et al., 1997; Miller, 1998). Similarly, higher levels of religiosity or spirituality among individuals recovering from substance abuse are also associated with enhanced coping, greater resilience to stress, an optimistic life orientation, greater perceived social support, and lower levels of anxiety among inpatient and halfway-house substance abusers (Pardini, Plante, & Sherman, 2001).

Religious and spiritual treatments have been effective in the recovery process of some individuals suffering from alcoholism (Navarro, Wilson, Berger, & Taylor, 1997; Schaler, 1996). Green, Fullilove, and Fullilove

(1998) describe the recovery experience for many substance abusers as an intense spiritual journey in which the individual embraces a higher power and undergoes a personal transformation. Carroll (1997) incorporates understanding of the self and others, as well as a higher power, in describing the spiritual journey of the substance abuser, emphasizing the importance of recognizing the relationship between one's spirituality and psychosocial functioning.

In a proposed sociospiritual approach to treating substance abuse addiction, Morrell (1996) identifies substance abuse as a condition dominated by a spiritual or social condition. Spiritual world views, along with political world views, serve to provide the individual with the conviction that human beings are interconnected through their beliefs in a higher power, decreasing feelings of separation and suffering.

Individuals treating clients with addictive disorders should take the spirituality of the client into account in using treatment strategies that properly reflect the needs of the client (Jackson, 1995). In a study comparing individuals in a substance abuse program with medical students in their attitudes toward issues of spirituality and the perceived importance of spirituality in treatment, it was found that the students significantly misassessed the value of spirituality in treatment for the clients (Goldfarb, Galanter, McDowell, Lifshutz, & Dermatis, 1996). The medical students in the study were found to be significantly less spiritually oriented than the clients (whose spirituality was representative of the population as a whole), and this factor may have contributed to the underestimation of their clients' desire or need for spiritual aspects of treatment. The authors suggest that medical students and other professionals whose careers are focused on biological sciences may need added training to adequately treat individuals who require spiritual components in therapy.

Alternatives to medically oriented therapy include intervention programs such as Alcoholics Anonymous and Narcotics Anonymous, which concentrate on such themes as accepting and relying on a higher power. In a study conducted by Pardini, Plante, and Sherman (2001), individuals recovering from substance abuse reported themselves as being more spiritual than religious, though they were found to have high levels of religiosity as well. Membership in the spirituality-based program Alcoholics Anonymous (AA) has been negatively associated with alcohol consumption, suggesting that it may be an effective method in modifying drinking behavior (Peele, 1997), although it has been difficult to conduct appropriate clinical trials to establish the efficacy of AA. Many individuals who are members of Alcoholics Anonymous found comfort in placing trust and responsibility for positive and negative events in their lives onto a higher power. Individuals in AA also expressed the desire to maintain their spirituality throughout their lives (Sommer, 1997).

However, there is controversy as to whether the apparent effectiveness of programs such as AA is due to their spiritual focus as opposed to other important elements, such as the social support offered through membership or the specific guidelines they provide concerning recovery (Vick, Smith, & Herrera, 1998). In a study examining the attitudes of individuals in a 12-step program (Nealon-Woods, Ferrari, & Jason, 1995), 71% of the individuals who attended weekly meetings indicated that they were not motivated by spiritual aspects of the meeting. Eighty-eight percent indicated that they benefited from working with a sponsor, and 53% indicated that they were involved with the program because it offered a sense of fellowship with others in need of similar recovery. Contrary to the belief that spirituality is a necessary component in treating addictive disorders, individuals attending meetings of secular programs, such as Secular Organizations for Sobriety (SOS) or secular professional addictions treatment, regard these programs as effective in achieving and maintaining abstinence (Connors & Dermen, 1996). When comparing the spirituality of individuals in a religious therapy group (12-step) with that of those in a nonreligious therapy group, spirituality levels of both groups were found to increase, regardless of treatment style (Borman & Dixon, 1998).

The issue of whether spirituality is a necessary component in the treatment of substance abuse is a difficult one to assess. Though some individuals purposefully choose treatment plans that are secular in nature, it is unclear whether the increased level of spirituality they may develop is due to the inherent spirituality of the individual substance abusers or whether the secular programs also offer spiritual support. Further research comparing secular and religious therapy and individuals who choose these various treatment programs needs to be conducted to gain more insight into the role that religion and spirituality play in the process of recovery from substance abuse.

SCHIZOPHRENIA

Whereas past research has suggested that religiosity may be positively associated with the incidence of schizophrenia, recent research has focused on the possibility that some religious individuals are misdiagnosed with schizophrenia. Behaviors or ideology that reflect normal religious functioning may overlap with schizophrenic characteristics. Wahass and Kent (1997b) highlight two case studies in which the clients' normal religious behaviors were assessed as schizophrenic, asserting that even the third revised edition of the *Diagnostic and Statistical Manual of Mental Disorders* might tend toward such misdiagnoses. A proper assessment for schizophrenia in religious patients can only be completed when taking into consideration the pre-morbid religious or spiritual ideology of the client. Whereas a therapist may

assess a client's psychopathology as schizophrenia, a religious client may diagnose himself or herself as struggling with spirit or demon possession. Understanding the client's perceptions of the phenomenon and his or her religious background may be helpful for therapists in both assessment and intervention strategies (Gopal & Sharon, 1997; Schneider, 1997; Wahass & Kent, 1997c).

In addressing the religious beliefs and background of an individual who is self-diagnosed with possession, intervention strategies may include more than the traditional administration of psychotropic medicine (Azaunce, 1995). For example, in many Middle Eastern cultures, psychiatric symptoms such as hallucinations are sometimes attributed to possession by demons or to God's will (Wahass & Kent, 1997a). When antipsychotic medication showed no positive outcome among Islamic schizophrenic clients, the integration of religious doctrine into therapy was effective with two-thirds of the clients (Wahass & Kent, 1997b). One possible treatment strategy for individuals of various religious beliefs includes the combined efforts of the psychotherapist and a religious or spiritual healer from the client's religious background, such as an exorcist, voodoo doctor, obeahman, or faith healer (Azaunce, 1995).

Schneider (1997) describes the "paranoid" religious thoughts of some schizophrenics "as an expression of healthy searching in the therapeutic process and not necessarily as a psychotic and unhealthy delusion" (p. 379). When religious delusions that are used as tools for fostering a normal sense of reality are perceived as psychotic, the person tends to create more delusions and appear more psychotic (Schneider, 1997).

Religious coping methods have been shown to have positive effects on individuals who are diagnosed with schizophrenia, as well as with their families (Wahass & Kent, 1995). The religious disposition of schizophrenic individuals tends to be consistent with their previous religious affiliation, even though their perceptions of the world may have become significantly impaired. For individuals who have the same religious affiliation as their families, religion can serve as a unifying force for all parties through the practice of traditional rituals and symbols which reflect the family's value system (Walsh, 1995). For the schizophrenic individual, religious worship with the family or with a congregation may serve to integrate the person into a greater community during times in which he or she is most likely feeling isolated. For the family, religious worship with the schizophrenic family member serves as a means of feeling connected with the individual who has lost touch with reality. The therapist's understanding and respect for the religious beliefs and practices of the client and the client's ability to use his or her natural coping mechanism have been helpful in treatment for Christian clients (MacGreen, 1997). In a cross-cultural study by Wahass and Kent (1997a) examining the use of coping mechanisms of Western and non-

Western schizophrenic clients, culture was related to the choice of coping mechanism employed.

The use of treatment strategies that include religious or spiritual components for schizophrenic clients seems to be important in providing optimum treatment outcomes. Cultural and religious differences among clients may dramatically vary the treatment methods that could be employed by therapists. The role of religion and the nature of the illness, the client's perceptions of the illness, and cultural differences should be taken into consideration for assessment and treatment (Fallot, 1998; Wahass & Kent, 1997a, 1997b).

PERSONALITY, EATING, SOMATOFORM, AND BIPOLAR DISORDERS

Few studies have been conducted regarding the relationship of religion/spirituality and personality, eating, somatoform, dissociative, or bipolar disorders. In relation to treating borderline patients, Vitz and Mango (1997) discuss the role of Kernbergian psychodynamics and religious aspects of forgiveness, emphasizing how repentance and forgiveness cannot be offered through psychotherapy but rather through religious and morality-based treatment approaches. Other research on personality disorders has been similar to recent research on schizophrenia. The increase in studies focusing on the misdiagnosis of schizophrenia in normal-functioning religious individuals is similar to research that presents the possibility that normal functioning religious individuals are misdiagnosed with schizotypal personality disorder (Day & Peters, 1998; Jackson & Fulford, 1997; McCreery & Claridge, 1995). McCreery and Claridge (1995) term individuals who are well adjusted but score high on scales measuring positive symptomatology for schizotypal personality disorder as "happy schizotypes." In studying new religious movements and schizotypy, Day and Peters (1998) found that an overlap existed between the experiences of individuals in these new religions and positive symptomatology. However, individuals in these new religions were not found to be distressed overall (Day & Peters, 1998; Jackson & Fulford, 1997). Abnormal religious experiences such as out-of-body sensations (McCreery & Claridge, 1995) and intense religious moments (Jackson & Fulford, 1997) may be common among individuals who are "happy schizotypes," but these types of experiences do not necessarily indicate the presence of mental illness or maladjustment (McCreery & Claridge, 1995).

Religion and spirituality have also been examined with respect to the etiology and treatment of eating disorders. In assessing possible causal factors of eating disorders, McCourt and Waller (1996) discuss how religion, along with other factors such as gender and acculturation, may have an

impact on eating disorders or disturbed eating attitudes. Some religious and spiritual beliefs that have been common among individuals with eating disorders include feelings of spiritual unworthiness, shame, fear of abandonment by God, and negative perceptions of God (P. Richards et al., 1997). Spiritual interventions have been found to be helpful with obese, overweight (Davis, Clance, & Gailis, 1999) and anorexic individuals (Garret, 1996; Banks, 1997). Obese women who attended meetings for Overeaters Anonymous, which focuses on abstinence and spirituality as emphasized in Alcoholics Anonymous, reported success rates that were significantly associated with the importance they attributed to abstinence and spirituality. Treatment interventions that integrate religious or spiritual components might also be employed in psychotherapy for obese individuals who either identify themselves as religious or are from religious or spiritual cultures, such as the African American community (Davis et al., 1999).

In an article highlighting a case study of somatization, Ruiz (1998) discusses the roles of religion in the client's conceptualization of the illness, the process of somatization, the client's difficulties with treatment compliance, and the integration of religion in the treatment process. In Ruiz's case study, a middle-aged immigrant woman who was experiencing a major depressive episode in conjunction with somatization disorder believed that she was not depressed but was being punished by God. She was administered antidepressants but refused to comply with any treatment by her psychiatrist until she was advised to do so by a priest in her local church. Religious or spiritual treatment plans were also considered to be important in the care of religious individuals with bipolar disorder (Fallot, 1998).

CONCLUSION AND FUTURE DIRECTIONS

Most research examining the relationship between religion and spirituality and mental health outcomes shows positive associations. Healthy religious functioning or a spiritual outlook on life has been clearly associated with mental well-being and negatively associated with depression, anxiety, and substance abuse. However, there are both positive and negative associations of religion and spirituality with anxiety and schizophrenia. More research needs to be conducted on whether the elevated incidence of these disorders among religious individuals is specific to those who have experienced strict or abnormal religious upbringings or whether these disorders are also found disproportionately among individuals with healthy religious upbringings. Likewise, more research needs to be conducted to understand the role of religion and spirituality in the incidence of other mental disorders, such as bipolar, somatoform, eating, or personality disorders.

Also, nearly all research has emphasized the importance of considering

the religious or spiritual background of individuals with mental illness to aid in assessment and the construction of effective treatment plans. Useful tools for assessment are vital in developing effective treatment strategies. One should take into account the relationship between sociodemographic factors and individuals' religious or spiritual beliefs. Likewise, it is also important to consider the specific cultural backgrounds of the individuals. Though many people around the world may have the same religious affiliation, religious beliefs and practices vary based on factors such as ethnic culture and family culture. To do a proper assessment, a therapist should investigate these influences. Integrating religion and spirituality into treatment may include the aid of religious professionals, such as clergy. Because trust is important to many individuals seeking therapy, religious individuals may feel most comfortable when treated by a trusted religious professional along with a psychotherapist.

Because religion and spirituality may play an important role in the etiology, assessment, and recovery process of some individuals with mental illness, holistic models that encompass religion and spirituality may be more useful than traditional models.

REFERENCES

- Alvarado, K., Temper, D., Bresler, C., & Dobson, D. (1995). The relationship of religious variables to death depression and death anxiety. *Journal of Clinical Psychology, 51*, 202-204.
- Azaunce, M. (1995). Is it schizophrenia or spirit possession? *Journal of Social Distress and the Homeless, 4*, 255-263.
- Banks, C. (1997). The imaginative use of religious symbols in subjective experiences of anorexia nervosa. *Psychoanalytic Review, 84*, 227-236.
- Barr, C. (1995). Panic disorder: "The fear of fearful feelings." *Journal of Psychology and Christianity, 14*, 112-125.
- Bennet, T., Deluca, D. A., & Allen, R. W. (1995). Religion and children with disabilities. *Journal of Religion and Health, 34*, 301-311.
- Bernstein, E., Calhoun, D., Cegielski, C., Latham, A., Shepherd, M.C., Sparks, K. J., Bickel, C., Ciarrocchi, J., Sheers, N., Estadt, B., Powell, D., & Pargament, K. (1995). Perceived stress, religious coping styles, and depressive affect. *Journal of Psychology and Christianity, 17*, 33-34.
- Bickel, C. O., Ciarrocchi, J. W., Sheers, N. J., Estadt, B. K., Powell, D. A., & Pargament, K. I. (1998). Perceived stress, religious coping styles, and depressive affect. *Journal of Psychology and Christianity, 17*(1), 33-42.
- Blaine, B., & Croker, J. (1995). Religiousness, race, and psychological well-being: Exploring social psychological mediators. *Personality and Social Psychology Bulletin, 21*, 1031-1041.
- Borman, P. D., & Dixon, D. N. (1998). Spirituality and the 12 steps of substance abuse recovery. *Journal of Psychology and Theology, 26*, 287-291.

- Braam, A., Beekman, A., Deeg, D., Smith, J., & Tilburg, W. (1997). Religiosity as a protective prognostic factor of depression in later life: Results from a community survey in the Netherlands. *Acta Psychiatrica Scandinavica*, 96, 199-205.
- Carroll, M. M. (1997). Spirituality, alcoholism, and recovery: An exploratory study. *Alcoholism Treatment Quarterly*, 15, 89-100.
- Catipovic, V., Ilakovac, V., Durjancek, J., & Amidzic, V. (1995). Relationship of eight basic emotions with age, sex, education, satisfaction of life needs, and religion. *Psychological Reports*, 77, 115-121.
- Chang, B., Noonan, A., & Tennstedt, S. (1998). The role of religion/spirituality in coping with caregiving for disabled elders. *Gerontologist*, 38, 463-470.
- Chapman, R. J. (1996). Spirituality in the treatment of alcoholism: A worldview approach. *Counseling and Values*, 41, 39-50.
- Clements, R. (1998). Intrinsic religious motivation and attitudes toward death among the elderly. *Current Psychology: Developmental, Learning, Personality, and Social*, 17, 237-248.
- Connors, G. J., & Dermen, K. H. (1996). Characteristics of participants in Secular Organizations for Sobriety (SOS). *American Journal of Drug Alcohol Abuse*, 22, 281-295.
- Cornet, C. (1998). *The soul of psychotherapy: Recapturing the spiritual dimensions in the therapeutic encounter*. New York: Free Press.
- Cosar, B., Kocal, N., Arikian, Z., & Isik, E. (1997). Suicide attempts among Turkish psychiatric patients. *Canadian Journal of Psychiatry*, 42, 1072-1075.
- Davis, N., Clance, P., & Gailis, A. (1999). Treatment approaches for obese and overweight African American women: A consideration of cultural dimensions. *Psychotherapy*, 36, 27-35.
- Day, S., & Peters, E. (1998). The incidence of schizotypy in new religious movements. *Personality and Individual Differences*, 27, 55-67.
- Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125, 276-302.
- Donahue, M. J., & Benson, P. L. (1995). Religion and the well-being of adolescents. *Journal of Social Issues*, 51, 145-160.
- Ellison, C. G. (1998). Introduction to symposium: Religion, health, and well-being. *Journal for the Scientific Study of Religion*, 37, 692-694.
- Emmons, R., Cheung, C., & Tehrani, K. (1998). Assessing spirituality through personal goals: Implications for research on religion and subjective well-being. *Social Indicators Research*, 45, 391-422.
- Fallot, R. (1998). The place of spirituality and religion in mental health services. In R. Fallot (Ed.), *Spirituality and religion in recovery from mental illness: New directions for mental health services* (pp. 3-12). San Francisco: Jossey-Bass.
- Fischer, L., & Richards, P. S. (1998). Religion and guilt in childhood. In J. Bybee (Ed.), *Guilt and children* (pp. 139-155). San Diego, CA: Academic Press.
- Fleming, M., & Anderson, B. (1998). Spiritual Well-Being Scale: Ethnic differences between Caucasians and African-Americans. *Journal of Psychology and Theology*, 26, 358-364.
- Frame, M. W., & Williams, C. B. (1996). Counseling African Americans: Integrating spirituality in therapy. *Counseling and Values*, 41, 2-16.

- Garret, C. (1996). Recovery from anorexia nervosa: A Durkheimian interpretation. *Social Science and Medicine*, 43, 1489-1506.
- Gilbert, B. (1998). *The pastoral care of depression: A guidebook*. New York: Haworth Pastoral Press.
- Gillis, J. S., & Mubhashar, M. H. (1995). Risk factors for drug abuse in Pakistan: A replication. *Psychological Reports*, 76, 99-108.
- Goldfarb, L. M., Galanter, M., McDowell, D., Lifshutz, H., & Dermatis, H. (1996). Medical student and patient attitudes toward religion and spirituality in the recovery process. *American Journal of Drug and Alcohol Abuse*, 22, 549-561.
- Gopal, M. (1997). The role of religion in psychotherapy: A cross-cultural examination. *Journal of Contemporary Psychotherapy*, 27, 34-48.
- Green, L. L., Fullilove, M. T., & Fullilove, R. E. (1998). Stories of spiritual awakenings: The nature of spirituality in recovery. *Journal of Substance Abuse Treatment*, 15, 325-331.
- Harrington, V., Lackey, N. R., & Gates, M. F. (1996). Needs of caregivers of home and hospice care patients. *Cancer Nursing*, 19, 118-125.
- Hinton, J. (1999). The progress of awareness and acceptance of dying assessed in cancer patients and their caring relatives. *Palliative Medicine*, 13, 19-35.
- Holtz, T. (1998). Refugee trauma versus torture trauma: A retrospective controlled short study of Tibetan refugees. *Journal of Nervous and Mental Diseases*, 186, 24-34.
- Hood-Morris, L. E. (1996). A spiritual well-being model: Use with older women who experience depression. *Issues in Mental Health Nursing*, 17, 439-455.
- Idler, E. L., & Kasl, S. V. (1997). Religion among disabled and non-disabled elderly persons: II. Attendance at religious services as a predictor of the course of disability. *Journal of Gerontology Series B—Psychological Sciences and Social Sciences*, 52B, S306-S316.
- Ita, D. (1995-1996). Testing of a causal model: Acceptance of death in hospice patients. *Omega*, 32, 81-82.
- Jackson, M. S. (1995). Afrocentric treatment of African American women and their children in residential chemical dependency program. *Journal of Black Studies*, 26, 17-30.
- Jackson, M. C., & Fulford, K. W. M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry, and Psychology*, 1, 41-65.
- Jahangir, F. (1995). Third force therapy and its impact on treatment outcome. *International Journal for the Psychology of Religion*, 5, 125-129.
- Jahangir, F., ur Rehman, H., & Jan, T. (1998). Degree of religiosity and vulnerability to suicidal attempt/plan in depressive patients among Afghan refugees. *International Journal for the Psychology of Religion*, 8, 265-269.
- Kaplan, M., Marks, G., & Mertens, S. (1997). Distress and coping among women with HIV infection: Preliminary findings from a multiethnic sample. *American Journal of Orthopsychiatry*, 37, 80-91.
- Kazanigian, M. A. (1997). The spiritual and psychological explanation for experience. *Hospice Journal*, 12, 17-27.
- Kendler, K. S., Gardner, C. O., & Prescott, C. A. (1996). Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. *American Journal of Psychiatry*, 154, 322-329.

- Koenig, H. (1995a). Religion and older men in prison. *International Journal of Geriatric Psychiatry*, 10, 219–230.
- Koenig, H. (1995b). *Research on religion and aging: An annotated bibliography*. Westport, CT: Greenwood Press.
- Koenig, H., Hays, J., George, L., Blazer, D., Larson, D., & Landerman, L. (1997). Modeling the cross-sectional relationship between religion, physical health, social support, and depressive symptoms. *American Journal of Geriatric Psychiatry*, 5, 131–144.
- Koenig, H., Weiner, D., Peterson, B., Meador, K., & Keefe, F. (1997). Religious coping in the nursing home: A biopsychosocial model. *International Journal of Psychiatry in Medicine*, 27, 365–376.
- Kok, J., & Jongsma, A. (1998). *The pastoral counseling treatment planner*. New York: Wiley.
- Levin, J. (1997). The role of the Black Church in community medicine. *Journal of the National Medical Association*, 76, 477–483.
- Levin, J., & Taylor, R. (1998). Panel analyses of religious involvement and well-being in African-Americans: Contemporaneous vs. longitudinal effects. *Journal for the Scientific Study of Religion*, 37, 695–709.
- Livneh, H., Antonak, R., & Maron, S. (1995). Progeria: Medical aspects, psychosocial perspectives, and intervention guidelines. *Death Studies*, 19, 433–452.
- Lotufo-Neto, F. (1996). The prevalence of mental disorders among clergy in Sao Paulo, Brazil. *Journal of Psychology and Theology*, 24, 313–322.
- MacGreen, D. (1997). Spirituality as a coping resource. *Behavior Therapist*, 20, 28.
- May, A. (1997). Psychopathology and religion in the era of “enlightened science”: A case report. *European Journal of Psychiatry*, 11, 14–20.
- McCourt, J., & Waller, G. (1996). The influence of sociocultural factors on the eating psychopathology of Asian women in British society. *European Eating Disorders Review*, 4, 73–83.
- McCreery, C., & Claridge, G. (1995). Out of body experiences and personality. *Journal of the Society for Psychological Research*, 60, 129–148.
- McCullough, M. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology*, 46, 92–98.
- Mickley, J., Carson, V., & Soeken, L. (1995). Religion and adult mental health: State of the science in nursing. *Issues in Mental Health Nursing*, 16, 345–360.
- Mickley, J., Pargament, K., Brant, C., & Hipp, K. (1998). God and the search for meaning among hospice caregivers. *Hospice Journal*, 13, 1–17.
- Miller, L., Warner, V., Wickramaratne, P., & Weissman, M. (1997). Religiosity and depression: Ten-year follow-up of depressed mothers and offspring. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 1416–1425.
- Miller, W. R. (1998). Researching the spiritual dimensions of alcohol and other drug problems. *Addiction*, 93, 979–990.
- Miller, W., & Thoresen, C. (1999). Spirituality and health. In W. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 6–19). Washington, DC: American Psychological Association.
- Morell, C. (1996). Radicalizing recovery: Addiction, spirituality, and politics. *Social Work*, 41, 306–312.

- Navarro, J., Wilson, S., Berger, L., & Taylor, T. (1997). Substance abuse and spirituality: A program for Native American students. *American Journal of Health Behavior, 21*, 3-11.
- Nealon-Woods, M. A., Ferrari, J. R., & Jason, L. A. (1995). Twelve-step program use among Oxford house residents: Spirituality or social support in sobriety? *Journal of Substance Abuse, 7*, 311-318.
- O'Neil, D., & Kenny, E. (1998). Spirituality in chronic illness. *IMAGE: Journal of Nursing Scholarship, 30*, 275-280.
- Pardini, D., Plante, T. G., & Sherman, A. (2001). Strength of religious faith and its association with mental health outcomes among recovering alcoholics and addicts. *Journal of Substance Abuse Treatment, 19*, 347-354.
- Pargament, K. I., & Park, C. L. (1996). Merely a defense? The variety of religious means and ends. *Journal of Social Issues, 51*, 13-32.
- Peele, S. (1997). Utilizing culture and behavior in epidemiological models of alcohol consumption and consequences for Western nations. *Alcohol and Alcoholism, 32*, 51-64.
- Plante, T. G., & Boccaccini, M. (1997). The Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology, 45*, 375-387.
- Plante, T. G., Manuel, G., Menendez, A., & Marcotte, D. (1995). Coping with stress among Salvadoran immigrants. *Hispanic Journal of Behavioral Sciences, 17*, 471-479.
- Plante, T. G., Saucedo, B., & Rice, C. (2001). The association between religious faith and coping with daily stress. *Pastoral Psychology, 49*, 291-300.
- Plante, T. G., Yancey, S., Sherman, A., Guertin, M., & Pardini, D. (1999). Further validation for the Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology, 48*, 11-21.
- Rajarithnam, R. M., & Muthusamy, R. (1996). Pattern of substance abuse in Salem: A three-year study. *International Medical Journal, 3*, 309-312.
- Rapheal, F., Rani, S., Bale, R., & Drummond, L. (1996). Religion, ethnicity and obsessive-compulsive disorder. *International Journal of Social Psychiatry, 42*, 38-44.
- Razali, S., Hasanah, C., Aminah, K., & Subramaniam, M. (1998). Religious socio-cultural psychotherapy in patients with anxiety and depression. *Australian and New Zealand Journal of Psychiatry, 32*, 867-872.
- Reese, D., & Brown, D. (1997). Psychosocial and spiritual care in hospice: Differences between nursing, social work, and clergy. *Hospice Journal, 12*, 29-41.
- Richards, P., & Bergin, A. (Eds.). (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.
- Richards, P., Hardman, R., Frost, H., Berrett, M., Clark-Sly, J., & Anderson, D. (1997). Spiritual issues and interventions in treatment of patients with eating disorders. *Eating Disorders: The Journal of Treatment and Prevention, 5*, 261-279.
- Richards, P., Rector, J. M., & Tjeltveit, A. (1999). Values, spirituality, and psychotherapy. In W. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 133-160). Washington, DC: American Psychological Association.

- Richards, T., & Folkman, S. (1997). Spiritual aspects of loss at the time of a partner's death from AIDS. *Death Studies*, 21, 527-552.
- Ruiz, P. (1998). The role of culture in psychiatric care. *American Journal of Psychiatry*, 155, 1763-1765.
- Schaler, J. A. (1996). Spiritual thinking in addiction-treatment providers: The Spiritual Belief Scale. *Alcoholism Treatment Quarterly*, 14, 7-33.
- Schneider, S. (1997). Jerusalem, religious awakenings and schizophrenia. *Group Analysis*, 30, 379-393.
- Selway, D., & Ashman, A. F. (1998). Disability, religion and health: A literature review in search of the spiritual dimensions of disability. *Disability and Society*, 13, 429-439.
- Shapiro, S., Schwartz, G., & Bonner, G. (1998). Effects of mindfulness-based stress reduction on medical and premedical students. *Journal of Behavioral Medicine*, 21, 581-599.
- Shooka, A., Al-Haddad, M., & Raees, A. (1998). OCD in Bahrain: A phenomenological profile. *International Journal of Social Psychiatry*, 44, 147-154.
- Sommer, S. M. (1997). The experience of long-term recovering alcoholics in Alcoholics Anonymous: Perspectives of therapy. *Alcoholism Treatment Quarterly*, 15, 75-80.
- Tapanya, S., Nicki, R., & Jarusawad, O. (1997). Worry and Intrinsic/extrinsic religious orientation among Buddhist (Thai) and Christian (Canadian) elderly persons. *International Journal of Aging and Human Development*, 44, 73-83.
- Thearle, M. J., Vance, J., Najman, J., Embelton, G., & Foster, W. (1995). Church attendance, religious affiliation and parental responses to sudden infant death, neonatal death and stillbirth. *Omega*, 31, 51-58.
- Trenholm, P., Trent, J., & Compton, W. C. (1998). Negative religious conflict as a predictor of panic disorder. *Journal of Clinical Psychology*, 54(1), 59-65.
- Varon, S. R., & Riley, A. W. (1999). Relationship between maternal church attendance and adolescent mental health and social functioning. *Psychiatric Services*, 50, 799-805.
- Vick, R. D., Smith, L. M., & Herrera, C. I. (1998). The healing circle: An alternative path to alcoholism recovery. *Counseling and Values*, 42, 133-141.
- Vitz, P., & Mango, P. (1997). Kernbergian psychodynamics and religious aspects of the forgiveness process. *Journal of Psychology and Theology*, 25, 72-80.
- Wahass, S., & Kent, G. (1997a). Coping with auditory hallucinations: A cross-cultural comparison between Western (British) and non-Western (Saudi Arabian) patients. *Journal of Nervous and Mental Disease*, 185, 664-668.
- Wahass, S., & Kent, G. (1997b). The modification of psychological interventions for persistent auditory hallucinations to an Islamic culture. *Behavioral and Cognitive Psychotherapy*, 24, 351-364.
- Wahass, S., & Kent, G. (1997c). The modification of psychological interventions for persistent auditory hallucinations to an Islamic culture. *Behavioral and Cognitive Psychotherapy*, 25(4), 351-364.
- Walsh, J. (1995). The impact of schizophrenia on clients' religious beliefs: Implications for families. *Families in Society*, 76, 551-558.
- Warfield, R. D., & Goldstein, M. B. (1996). Spirituality: The key to recovery from alcoholism. *Counseling and Values*, 40, 196-205.

- Watson, P., Milliron, J., Morris, R., & Hood, R. (1994). Religion and rationality: II. Comparative analysis of rational-emotive and intrinsically religious irrationalities. *Journal of Psychology and Christianity, 13*, 373-384.
- Wilcock, A., Van Der Arend, H., Darling, K., Scholz, J., Siddaly, R., Snigg, C., & Stephens, J. (1998). An exploratory study of people's perceptions and experiences of well-being. *British Journal of Occupational Therapy, 61*, 75-82.
- Wing, D. M., Crow, S. S., & Thompson, T. (1995). An ethn nursing study of Muscogee Indians and effective health care practices for treating alcohol abuse. *Family and Community Health, 18*, 52-64.
- Woods, T., Antoni, M., Ironson, G., & Kling, D. (1999) Religiosity is associated with affective and immune status in symptomatic HIV-infected gay men. *Journal of Psychosomatic Research, 46*, 165-176.