MENTAL HEALTH AND RELIGION:
AN INVESTIGATION OF THE IMPACT OF RELIGIOUS BELIEF ON MENTAL HEALTH INTERVENTIONS

by

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DECLARATION

Unless specifically indicated to the contrary in the text,

this dissertation is the original work of the writer.

A.R. JOHNSON

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ABSTRACT

This study investigates two facets of the relationship between mental health and religion. The first is an investigation into the effects of psychologist's and psychiatrist's religious belief on their assessments of a religious client. Previous research has argued that non-religious mental health workers display bias against their religious clients (Houts and Graham, 1986; and Jones, 1994). Other research has suggested that extrinsically religious individuals and indiscriminately religious individuals tend to be more prejudiced than non-religious or intrinsically religious individuals (Donahue, 1985; and Richards and Bergin, 1997). The second facet of this study is an investigation into the differences between ministers of religion and mental health workers (psychologists and psychiatrists) in their assessment of a religious client. The DSM IV (APA, 1994) suggests that mental health workers should consider the cultural appropriateness of an individuals "symptoms" or behaviours before diagnosing them. It is argued here that psychologists and psychiatrists do not give due regard to the cultural appropriateness of their client's religious beliefs and the ministers of religion offer a gauge of what is culturally appropriate. To investigate these questions a group of mental health workers (consisting of 19 psychologists and 9 psychiatrists) and a group of Christian ministers of religion (consisting of 13 Pentecostal ministers and 17 mainstream ministers) was asked to complete a questionnaire based on a hypothetical case study. The hypothetical case study was constructed to have ambiguous religious characteristics, to allow the respondents to interpret the information according to their own biases. The questionnaire included Allport and Ross's Religious Orientation Scale (ROS) (Wulff, 1991). Data were analysed using Mann-Whittney U-tests and Kruskal Wallis H-tests. Significant differences were found between ministers of religion and mental health workers on most variables, with the greatest differences being evidenced between Pentecostal ministers of religion and psychiatrists. This suggests that mental health workers perceive religious clients as more mentally ill than ministers of religion do. However, no differences were found between mental health workers of different religious orientations according to the ROS and other measures of religiousness. This implies that mental health workers are not biased based on their own religious faith, but all mental health workers may be indiscriminately biased against religious individuals.

1. INTRODUCTION

Religious beliefs form an important part of the lives of most people. According to the 1996 South African census, approximately 87% of the South African population professes affiliation to some religious faith (Statistics South Africa, 1999). It is estimated that approximately 90% of the American population also have some religious affiliation (Larson, Pattison, Blazer, Omran and Kaplan, 1986). Psychologists and psychiatrists have lower rates of religious affiliation than the general population in America and tend to have higher levels of affiliation with non-traditional religions (Jones, 1994; Kroll and Sheehan, 1989; Larson et al, 1986).

Generally psychology and psychiatry have historically downplayed the role of religion in their client's lives through their theories and practice (Bergin 1983; Jones, 1994; Richards and Bergin, 1997). In recent years there has been a resurgent interest in religion amongst psychologists and psychiatrists in America, and an increasing acceptance of the importance of religion in people's lives (Esau, 1998; Richards and Bergin, 1997; Shaver, Lenauer and Sadd (1980). However, psychologists and psychiatrists continue to display bias against religious individuals (Houts and Graham, 1986, Jones, 1994).

Research has shown religion to have both positive and negative impacts on mental health and on individual's propensity to be biased or prejudiced against others (Wulff, 1991). Allport and Ross (1967) proposed that these conflicting results were attributable to two distinct types of religiousness. They suggested that *Extrinsic* religious belief, defined as a utilitarian faith that uses religion to obtain status, security, sociability and self-justification, was linked to higher levels of prejudice. By contrast, *Intrinsic* religious belief, an internalised belief in which religion provides meaning and satisfaction for the individual, is unrelated to prejudice, and may even display less prejudice than non-religious belief (Allport and Ross, 1967; Donahue, 1985; Wulff, 1991). Allport and Ross developed the Religious Orientation Scale (ROS) to assess whether individuals are intrinsic or extrinsic in their religious orientation. The first focus of this study is to investigate whether religious belief in psychologists and psychiatrists may bias their assessments of a religious client using the ROS.

Psychology has historically focussed on the link between religion and mental illness, but in the past two decades has gradually examined the link to mental health. However, despite clauses in the DSM IV (American Psychiatric Association, 1994) that therapists should consider the cultural appropriateness of a client's behaviour, many psychologists and psychiatrists appear to diagnose religious behaviours as symptoms of mental illness (Littlewood and Lipsedge, 1997). Therefore, this study's second aim is to investigate the tendency for psychologists and psychiatrists to interpret religious experience as psychopathology in contrast to the approach taken by ministers of religion. Thus, a group of Christian ministers of religion was requested to review the same hypothetical case study of a religious individual as the groups of psychologists and psychiatrists. It is theorised that the Christian ministers of religion would represent the views of the Christian community towards a the Christian client in the hypothetical case study, and thus provide a guideline of appropriate religious belief and behaviour for the mental health professionals to follow.

2. LITERATURE REVIEW

2.1. A brief history of the psychology of religion.

2.1.1. The rift between Psychology and Religion

An important area to begin reviewing the literature in this thesis is with the history of psychology and religion. This will provide the reader with an understanding of some of the current underlying issues in the field and provide some insight into the hypothesised attitudes of mental health professionals to cases in which the client holds religious beliefs.

Belzen (1992) in his article "The psychopathology of religion", illustrates how psychology was inseparable from religion from the beginning of psychological thinking. He traces thought back in history to ancient authors such as Hippocrates and Aristotle who discussed illness in terms of both natural and supernatural explanations. Thus he illustrates that dualism, or the belief that the body and soul were separate, the precursor of modern psychiatry, has existed for many years. Although this body of thought declined in popularity it regained its prominence during the enlightenment.

The majority of people during the Middle Ages, according to Belzen (ibid.), followed the belief that the body and the soul were one entity. As a consequence they posited religious explanations for any form of mental illness, such as demon possession and witchcraft. Although this was the dominant belief during the Middle Ages, the Enlightenment and the introduction of experimental methodology in medicine raised the profile of the dualists. The direct result was that they began to assert that, although God may exist, there are somatic or bodily explanations for mental illness, even if they have not yet been discovered. From this body of thought, psychology began to assert itself as a true science, consequently shifting away from the 'mystical beliefs' of religion to a view of mental illness as a disease of the brain or nerves. Because of the nature of religion as being

based on faith and subjective experience, science believed it could have no relationship with religion, other than as an object of empirical investigation (Jones, 1994). It is therefore ironic to note that psychiatry and psychology take their name from the word "psyche", implying soul or spirit.

Richards and Bergin (1997) suggest that as a result of attempting to represent itself as a science, psychology felt a need to distance itself from the "unscientific and mystical" beliefs of religion. They argue that instead, psychology based its assumptions on faith in the methodology of science and its resultant ability to explain all things. They argue that, because of this emphasis on being scientific, and because the founders of most of the major psychological theories (Freud, Watson, Skinner, Bandura and Rogers) were atheist, psychology not only moved away from being religious but portrayed religion in a negative light. Accordingly, Freud asserted that when patients spoke of demon possession they were using a psychological metaphor for the dark intra-psychic forces which they felt were dominating them (Belzen, 1992). Bergin (1980b) and Vande Kemp (1997) further note that the move against religion within the field of psychology may, quite understandably, have been reinforced by religion's history of prejudice, wars, harsh punishments of supposed witches and other atrocities all committed in the name of religion. Both authors acknowledge this as a valid fear. However, they suggest that in the process psychology failed to recognise the benevolent effects of religion.

Vande Kemp (1997) notes with concern that, despite an increased awareness of the role of religion in psychology, there are still very few references to it in introductory textbooks on psychology. She cites Gordon Allport's (1948) criticism of a fellow author "that the author is gratified by the alleged decline in influence [of religion] is, on the whole, more convincingly demonstrated than the fact of the decline itself" (Vande Kemp, 1997, p.84) as a valid observation of modern psychological authors. Richards and Bergin (1997) claim that approximately 27 percent of introductory psychological texts published in the 1970s contain some mention of religion, but the majority of these refer to Freud and his negative views of religion, or to Jung's explanations of religion, which Esau (1988) argues were certainly no return to religious faith.

Corveleyn and Lietaer (1994) suggest that psychiatry has displayed even less interest in religion than psychology. They discuss how the "Comprehensive Textbook of Psychiatry" by Kaplan and Saddock published in 1989, mention religion only as one possible topic of enquiry in the psychiatric list and only briefly discuss it as a potential source for prejudice. By ignoring any reference to religion, Vande Kemp (1997) argues that psychiatry and psychology are giving it the silent treatment in the hopes that it will go away, implying that it is an unworthy topic of discussion for the mental health field. McLemore and Court (1977) resolutely argue against this manner of treating religion in the mental health field and suggest that it needs to be actively confronted.

Bergin (1980a) suggests that psychologists' censorship of an issue that the majority of the population considers an important part of their lives, purely because they do not approve of it, is arrogant and unjustified. Bergin (1983) further argues that, although psychology is obviously predicated on empirical bases, the areas being examined are subjectively chosen and as a result, the non-religious bias of the literature is a consequence of ideological choices made by researchers in the field. He suggests that "race, gender and ethnic origin now receive deserved attention, but religion is still an orphan in academia" (Bergin, 1983, p.171), a point of view strongly supported by McLemore and Court (1977).

Esau (1998) notes that many of the early psychoanalysts, such as Freud, argued that religious faith was little more than a neurotic coping mechanism. Littlewood and Lipsedge (1997, p.170) submit that many psychiatrists in practice today hold a similar belief to Freud, that faith in God is "so patently infantile, so incongruous with reality, that to one whose attitude to humanity is friendly it is painful to think that the great majority of mortals will never be able to rise above this view of life". Section 2.2.3 will demonstrate how the current psychological literature abounds with studies claiming to show evidence that religion predisposes one to mental illness. Ellis (1980, p.635) claims that "extreme religiosity...is essentially emotional disturbance". Others, such as Dittes (1969), assume that only people with "weak egos" and personality impairments are attracted to religion (cited in

Schumaker, 1992). At the very least, suggests Bergin (1980a), modern psychology is indifferent to God and the possible validity of religion. The lack of strong and robust research in the field of psychology and religion has merely perpetuated this view (Richards, Srnith and Davis, 1989).

Wulff (1997) suggests that there have been two trends within the field of psychology of religion: the descriptive and the explanatory. The descriptive trend consists of religiously committed researchers who seek to document the varieties or types of religion, usually with the goal of fostering religious life. The explanatory trend is in opposition to this and usually seeks to find the origins of religious life, thus explaining it away in psychological terms and ultimately negating the validity of religion. Sevensky (1984) points out that, as a result of these two extreme points of view, historically there has been a great deal of suspicion by psychologists of religious practitioners and by religious practitioners of psychologists. Peteet (1981) suggests that this has occurred to such an extent that many religious communities actively discourage their members from attending psychotherapy. Larson et al. (1986) propose that this may be a symptom of the lack of communication between the two fields and the consequent lack of knowledge of how their field is perceived by the other.

Attempts by psychologists to explain religious phenomenon have often been perceived by religious practitioners to be attempts to prove religion false. Similarly, attempts by religious practitioners and religiously oriented psychologists to describe and assert the validity of religion as a construct have often met with criticism and contempt from non-religious psychologists. Esau (1998) suggests that Evangelical Christianity saw early psychoanalysis as a threat to its integrity in much the same way that Darwinism was perceived to threaten religion's validity. Jones (1994) suggests that the four major paradigms of psychology have all attempted to discredit or even dismiss religious traditions at some time during the course of their history.

Hogan (1979), then section editor of the Journal of Personality and Social Psychology, said "religion is the most important force in the history of man ... But in psychology, anyone who gets involved in or tries to talk in an analytic, careful way about religion is immediately branded a meathead; a mystic; an intuitive, touchy-feely sort of moron" (cited in Bergin, 1980, p.99).

Contrary to trends in the United Kingdom, the general population in America has shown a tendency toward renewing a commitment to traditional religious values, whereas the mental health profession, and in particular psychologists, has tended to remain less religious by comparison (Houts and Graham, 1986). Houts and Graham suggest that the consequence of this discrepancy between value systems may be a tendency for mental health practitioners to perceive their religious clients as more pathological than comparable non-religious clients. Another consequence of these disparate value systems may be that the mental health profession has treated religion as an object to be studied or reformed, ignoring the possibility of a relationship between psychology and religion that is predicated on mutual respect and understanding (Jones, 1994).

2.1.2.The re-emergence of religion as a popular topic in psychological literature

The latter half of the twentieth century saw a growing disillusionment with the positivistic and reductionist scientific approach which had come to dominate psychology (Bergin, 1980a). Phenomenology and the increasingly popular post-modern paradigm argue that there are no absolute answers and no wrong or right answers (Belzen, 1992; Richards and Bergin, 1997). Within this paradigm shift, it became possible for the disciplines of mental health and religion to undergo a period of rapprochement, where mental health practitioners acknowledged that people tend to turn first to their pastors when in distress. There appears also to have been an acceptance by the religious profession that psychology had much to offer their congregations (Esau, 1998).

Richards and Bergin (1997) suggest that this increased acceptance of religion by psychology was also precipitated by a reversal of the anticipated decrease in the general population's interest in religion. Argyle and Beit-Hallahmi (1975) suggest that, up until the mid 1970s, although the number of people expressing an interest in religion in Europe has decreased, in the USA it has remained much the same. Shaver et al. (1980) suggest that interest in religion has increased since the 1970s in the USA, and suggests that the USA is seeing a religious revival. They do, however note that this revival has been in different directions to the traditional religion in the USA with greatly increased interest in the Charismatic or Pentecostal movement and the eastern religions. The trend in the United Kingdom has been for religious interest to continue declining throughout the past two decades, although Smith (1998) suggests that the United Kingdom is now beginning to show a resurgence in interest in religion.

Shaver et al. (1980) suggest that psychologists in the USA could no longer ignore the revived interest in religion and consequently began to investigate it. The resurgence of interest in religion and spirituality has seen an explosive increase in the number of television programmes and magazines dedicated to religion (Richards and Bergin, 1997). This renewed interest in religion has also led to a rapid increase in research conducted into psychology and religion over the past twenty years. The increase in research was further encouraged by the introduction of the American Psychological Association's Division 36 which deals with religious issues (Bergin, 1980a).

Shafranske and Maloney (1990) suggest that the introduction of a specialised division for psychology and religion and the increased interest in research in the area is based on the realisation by mental health researchers that religious beliefs, traditions and experiences play an important role in people's lives. They cite Feifel (1958) as arguing that "regardless of our own religious or non-religious commitments or attitudes we need to accept and understand the individual's religious situation as a significant area in [each person's] life" (cited in Shafranske and Maloney, 1990, p. 72). Schumaker (1997), Wulff (1997) and Corveleyn and Lietaer (1994) suggest that the

amount of literature being produced in the 1990s on mental health and religion is astonishing, considering the hostility and indifference from mental health practitioners in the past. They cite several major journals in the secular psychology field that have dedicated issues to the study of psychology and religion as evidence of this trend:

- The first volume of *Psychotherapy* in 1990 was a special issue on Psychotherapy and Religion;
- The fourth volume of *The Counselling Psychologist* was dedicated to "religious faith across the life span"
- *Individual Psychology: the Journal of Adlerian Theory, Research and Practice* dedicated a volume to "pastoral counseling and the Adlerian perspective" in 1987
- Two debates were held in the *Journal of Consulting and Clinical Psychology* about religious ethical values and psychotherapy in 1980.

Richards and Bergin (1997) argue that, concurrent with this increased interest in the field of psychology of religion has been a gradual change in the view that religion and mental illness go hand in hand. They suggest that this change has only come about in force since the 1980s, but suggest that religion is increasingly being linked to positive mental health in the growing body of literature, a view supported by Wulff (1991), Worthington (1988), Worthington, Kurusu, McCullough, and Sandage (1996), Schumaker (1992), Bergin, Masters, and Richards (1987), Bergin, Stinchfield, Gaskin, Masters, and Sullivan (1988) and Shafranske (1997).

Some authors (Richards and Bergin, 1997; Richards and Potts, 1995) have proposed that mental health practitioners integrate a spiritual counselling strategy into their repertoire. Richards and Potts (1995) cite several studies which have been conducted in the past 15 years that investigated the use of spiritual or religious strategies (such as prayer, the use of scripture, etc.) in the psychotherapeutic process, while Pargament (1997) reviews research of the use of religion in coping. Although this trend has several critics, and Richards and Potts themselves realise the need for effective outcome based studies with these approaches, it is an indication of the change in the way the mental profession views religion. They argue that despite the potential problems that may

be associated with using a spiritual strategy for psychotherapy, one can no longer ignore the need to acknowledge the importance of spiritual or religious aspects of some people's lives.

2.1.3.Conclusion

The history of the psychology of religion is critical to any discussion of religion within the body of mental health because of its history of tense and ambivalent relationships with the field. It is apparent from the literature that there has been an historical tendency for mental health practitioners and religious practitioners to disagree on issues relating to the psychology of religion. Most psychologists and psychiatrists have either ignored religion as a factor in their client's lives or they appeared to view it as being associated with mental illness. Although this view is gradually changing and it is increasingly recognised that religion may be associated with better mental health, this has only begun in the past 20 years. This suggests that psychologists and psychiatrists who were trained and qualified more than 10 years ago may be expected to have a more negative view of religious belief and practice than those who are more recently trained and qualified.

2.2. The role of values in mental health.

"Therapeutic values are inherent in any theory of counselling because all theories take as their primary goal helping clients change for the better. A change for the better either explicitly or implicitly encourages, discourages, ignores, or deemphasizes (sic) religion" (Worthington, 1988, p.167). It becomes obvious therefore that a discussion of client and therapist values is necessary to any discussion of mental health practitioners and their religious clients.

Before pursuing a discussion of the role of values in mental health, it is important to define values. Rockeach (1973, in Worthington, 1988, p. 166) defines a value as "an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-

state of existence". Thus, "an enduring organization of beliefs conceming preferable modes of conduct or end-states of existence along a continuum of relative importance" is a value system (ibid.).

2.2.1.Levels of religion in the general population

Contrary to the expected trend at the beginning of the twentieth century, the number of people professing a belief in God had stayed more or less the same in the USA over the past 50 to 100 years. Several authors (Hoge, 1997; Richards and Bergin, 1997; Sevensky, 1984; Dishington, 1996; Bergin, 1980a; Shafranske, 1997) use statistics from the latest Gallup poll which suggests that 95% of the population in the USA believe in God, while about 70% profess church membership and 80% indicate that religion is important in their lives. Larson et al. (1986) review several studies of the population in the United States and agrees that over 90% profess some religious faith, whilst 40% attend regular religious services, and suggests this has remained constant since the 1940s.

Other important indications of religious belief are the percentage of people believing religion is the most important influence in their lives (56 to 72%), those believing in life after death (67%), and those being "born again" (34%) (Sevensky, 1984 and Jones, 1994). Kroll and Sheehan (1989) and Hoge (1997) note that there is an increasing trend amongst people believing in God to shift toward conservative, fundamentalist and charismatic Christian beliefs. They also note a tendency for more people to show affiliation to religious views and practices that are less conventional in Western society, such as Buddhism and other Eastern Religions.

Bergin and Jensen (1990) suggest that there is not much research into the religious beliefs of clients of mental health workers, an important distinction from the general population. However, Kroll and Sheehan (1989) suggest that the clinical population of inpatients that they surveyed in the USA fell in line with the general population.

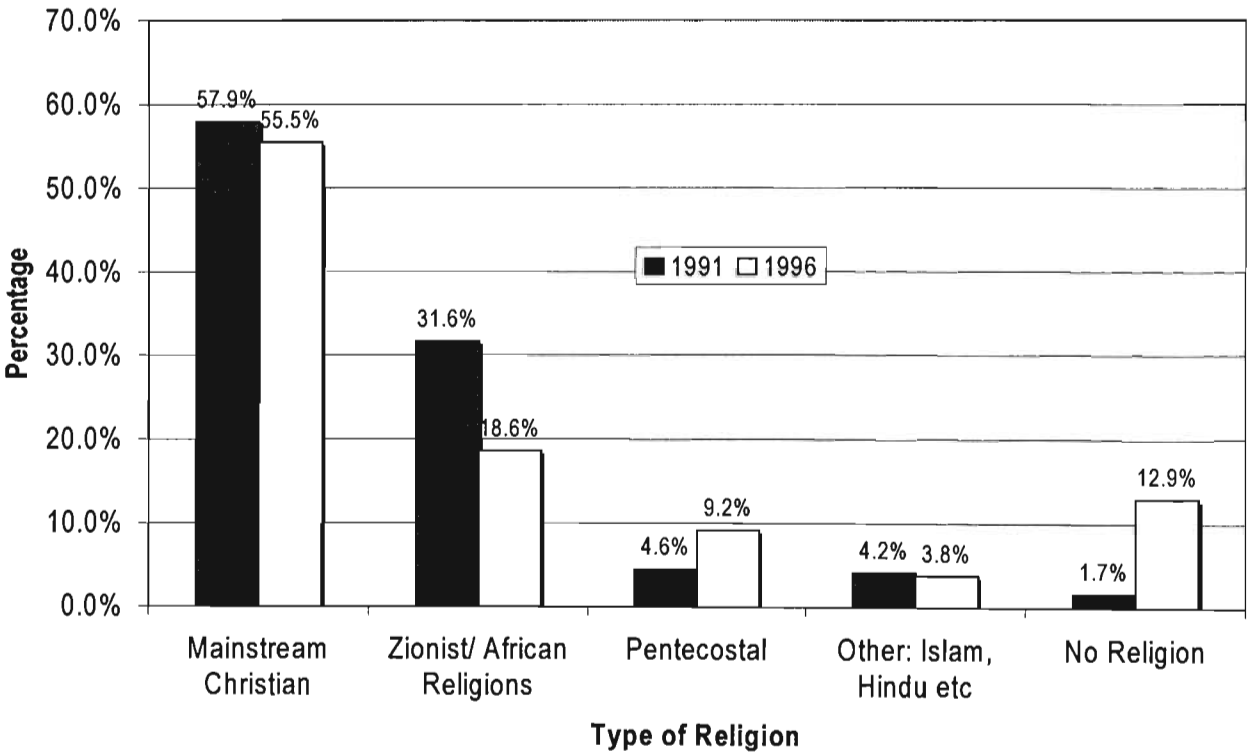
Argyle and Beit-Hallahmi (1975) contended that by 1975 there had been a decrease in church membership and religious belief in the United Kingdom, claiming that (in 1975) 80% of the population believed in God. Interestingly, however 40% were still regularly attending church, the same as the USA statistics. Perhaps this is an indication that those who have lost interest in religion were the more marginal believers and that the number of committed believers has stayed constant. Hoge (1997) argues that, whereas this trend was reversed in the United States, it has increased in Europe. He asserts that "Christian churches are nearly empty in northern Europe" (Hoge, 1997, pg. 23). This decrease in religious interest in Europe is confirmed by Smith (1998), but he argues that the trend is gradually beginning to reverse in East London where there is a re-emergence in religious interest.

Statistics for religious belief and affiliation in South Africa show a rather different pattern to those in Europe and the USA (Kellerman, 1972). Although the body of research dealing with religious affiliation of the population is not as extensive as in the United States, figures from the most recent censuses give an indication of the population's beliefs (Central Statistical Services, 1991; Statistics South Africa, 1999). In 1996, as illustrated by figure1, 55.5% of South Africa's population identifies itself with Mainstream Christian religions. A further 9.2% identify themselves with Pentecostal Christian churches. A large part of the population, 18.6%, identified itself with Zionist and African religious belief. Nearly 13% of the population claimed to have no religious belief at all, while the remaining 3.8% identified themselves with other religions (Islam, Hinduism, etc.).

Table 1 suggests that there has been a sharp rise in the proportion of the South African population professing not to have any religious affiliation from 1991 to 1996 at the expense of the Zionist and traditional African Religions. Similarly, there appears to have been a doubling of the number of people attending Pentecostal Christian churches. However, the 1991 statistics should be considered with a degree of caution, since the apartheid government of the time may not have collect completely accurate statistics for the African, Coloured and Asian

sectors of the South African population. The large drop in the percentage of the Zionist and African religion section from 1991 to 1996 may be due to an incorrect attribution of traditional African Religious belief to members of the African public. A further cause for caution in interpreting the statistics is the large percentage of the population that did not disclose their religious affiliation in the 1991 census (9.2 million as opposed to 3.7 million in 1996).

Figure 1: Religious Affiliation of the South African population in 1991 and 1996 (Figures from Central Statistical Services, 1991 and Statistics South Africa, 1999).



2.2.2.Religion amongst mental health practitioners

There appears to be little research into the religious affiliations of mental health practitioners in South Africa, and consequently statistics from the USA and Europe will have to be used. However, these may not be vastly different from the South African statistics as most of the South African training programmes are based on

programmes from the Western world. The Health Professions Council of South Africa, the registration body of psychologists and psychiatrists in South Africa, has no statistics on the religious affiliation of it members. Nevertheless, it may be hypothesised that South African psychologists would be more religious than their American counterparts as psychology in South Africa has typically been the domain of Afrikaans speaking whites from a Dutch Reformed Church background. The current composition of psychologists may also involve an increasing number of traditional African religious beliefs as more black psychologists become registered. There appears to be no consistent findings on the rates of religiousness in mental health practitioners in the literature, but a review will be given of several of the various studies.

One apparent consensus from the literature is that mental health practitioners appear to have a substantially lower rate of religious belief than the general population. Most researchers suggest that between 40 and 70% of psychiatrists believe in God (Kroll and Sheehan, 1989; Galanter, Larson and Rubenstone, 1991), while the figure for psychologists is generally placed between 40 and 50% (Larson et al., 1986; Jones, 1994).

Shafranske and Maloney (1990) found the number of psychologists having some religious affiliation to be higher at 71%, but this figure fell to 41% when one included regular participation as a criterion. Bergin and Jensen (1990) found 80% of their surveyed therapists held some religious belief, while Bergin (1991) found 77% of mental health practitioners tried to live by their religious beliefs, while at least a third attend religious services regularly. A caution that needs to be levelled against the work of both Bergin (1991) and Bergin and Jensen (1990) is that they included marriage and family therapists and social workers. The figures regarding religious belief are lower when one looks specifically at psychologists, 30% had no belief in God, 65% believed in traditional religions, and the remaining 5% in non-traditional religions. For psychiatrists, 24% indicated no religious belief and 65% indicated traditional religions. It is also worth noting that the psychiatrists had a significantly lower response rate than the other groups, thus biasing the total sample. This research is however consistent with other evidence that indicates that psychiatrists are less likely to belong to a church than other

doctors, and psychologists are less likely to belong to a church than other mental health practitioners (Littlewood and Lipsedge, 1997).

Even allowing for the possibility that those who completed the studies (between 40% to 66% of respondents (Shafranske and Maloney, 1990; Bergin and Jensen, 1990; Bergin, 1991)) may have been biased towards religion, this is indicative of higher rates of religion in the mental health profession than had been previously believed. However, there may still be a religiosity gap between the public and the mental health profession. Bergin and Jensen (1990) suggest that this discrepancy may be a simple matter of demographics, that mental health professionals may have higher levels of education, income and family class background, all associated with lower levels or religious belief.

However, these figures are not uncontested. Larson et al. (1986) cited an unpublished study by Ragan et al. that suggested only 5% of those with membership of the American Psychological Association believed in God. In light of the discrepancy between these findings and other studies, one must question the methodology and definitions used by Ragan et al. and the reasons for the research remaining unpublished.

Jones (1994) found that 33% of psychologists claimed that religious faith was the most important factor in their lives, whilst Sevensky (1984) suggests only 32% of medical professionals believed in life after death, both substantially less than half the general population. Shafranske and Maloney (1990) found that less than one fifth of psychologists felt that organised religion was their primary source of spirituality. Thus, a larger proportion of psychologists identifiy with informal religions than the general population. This may further exacerbate the difference between mental health professionals and the general population since the general population appears to be moving towards more mainstream, conservative denominations (Kroll and Sheehan, 1989).

Even when therapists are religious they do not necessarily see a role for religion within the process of psychotherapy. Richards and Potts (1995) surveyed 215 Mormon therapists on the approaches that they use during their therapy, and they found that as much as seventy-three percent said they believed there are some religious strategies that therapists should not use in therapy. Shafranske and Maloney (1990) found that only 53% of psychologists rated having religious beliefs as desirable for the general population, regardless of their own religious affiliations.

"The main findings show that the beliefs of mental health professionals are not very harmonious with those of the subcultures with which they deal, especially as they pertain to...the relevance of moral behaviour to...prevention of pathology, and development of the self" (Bergin, 1980a, p.101). Jones (1994) suggests that many psychologists cannot relate to religion and in consequence maintain a neutral position towards it. He argues that this is not an antagonistic stance, but merely the only way that they can see of interacting with something that they do not understand. He argues that as an atypical sub-population in religious terms, mental health practitioners "may misunderstand or inappropriately evaluate client religiosity and the place of faith in their lives" (Jones, 1994, p.192). This is important considering this study's investigation into mental health professionals' perceptions of religion and its links with mental illness.

2.2.3.Therapist values and their effect on therapist-client interaction

Houts and Graham (1986) and Jones (1994) warn that the differences between the religious beliefs of mental health practitioners and their clients may lead them to inappropriately evaluate their clients' religiosity and suggest that they may perceive their religious clients as more pathological than comparable non-religious clients. Larson et al. (1986) suggest that the lower rates of religious belief amongst mental health workers has led to very different conceptions of religion than those held by the religious public. Religion is usually investigated as a source of potential psychopathology and is not often viewed as a healthy part of life (ibid., Bergin, 1983,

Sevensky, 1984). Non-religious therapists may also devalue the importance of religion in their clients' lives and be prejudiced against their religious clients (Bergin, 1983; Dishington, 1996; Sevensky, 1984; Tillman, 1998). Littlewood and Lipsedge (1997) observed that one religious congregation in the United Kingdom appealed to the archbishop of Cantebury to intervene after psychiatrists had been diagnosing religious people as insane. Consequently, these theorists point to the necessity for mental health practitioners to be aware of the interaction between their own values and the values of their clients (ibid.).

Early theorists suggested that to address the influence of values and prejudice in therapy, therapist should remain neutral during therapy. However, it is now widely acknowledged that one can never be neutral in therapy (Bergin, 1980a, 1991; Coyne, 1976; Littlewood and Lipsedge, 1997; McLemore and Court, 1977; Richards and Bergin, 1997; Sevensky, 1984; Tillman, 1998; Worthington, 1988). They reason that psychotherapy is not a technical procedure like surgery, but actively involves the therapist and therefore the therapist's attitudes and values interact with those of the client in the treatment process. As such, Bergin (1980a) cites two studies showing that even Carl Rogers reinforced behaviours in his clients by approving or disapproving of them. Bergin suggests that if not even Carl Rogers can be non-directive, it seems unlikely that most other therapists can be!

Wulff (1997) suggests that in any research and theory formation, theorists choose a field and frame of reference that is based upon their own past experience. Therefore psychological theories carry the theorist's implicit assumptions of what constitutes good or healthy behaviour and what constitutes bad or unhealthy behaviour (Bergin, 1980a). This is further compounded by psychological training programmes being less likely to admit religious students, thus reinforcing the field's non (or anti) religious approach (Lewis and Lewis, 1985). A debate which took place in the pages of the *Journal of Consulting and Clinical Psychology* offers a fine illustration of this point. Ellis (1980) asserted that it is better to be non-religious but, if one needs something to lean on, religion may be acceptable as long as it does not hold a position of predominance in one's life. This assumption was not based on research, but on Ellis's personal point of view (Bergin, 1980b; Corveleyn and Lietauer, 1994).

The anti-religion bias is exemplified in the lack of published research on the psychology of religion from 1900 to the late 1970s, and the subsequent abundance of literature on the topic (Richards and Bergin, 1997). It may be argued that those who were interested in understanding human behaviour from a religious perspective would have studied theology and those who were not interested in religion would most likely have sought to understand it through psychology. Thus, the change has not occurred because psychology of religion is newly created, but because of a renewed interest in the topic. This does not mean that one must reject all theories, but rather that they should be understood in the light of the theorists' backgrounds and their religious stances. Wulff (1997, p.66) therefore argues "the theories that we find most compelling in the psychology of religion will likely be the ones that best account for religion as we experience or understand it".

Abramowitz and Dokecki (1977) concluded that client values are the second strongest predictor of therapist bias behind social class in their summary of the role played by values in the relationship between therapist and client. Although they pay little attention to religion as a specific value, it may be hypothesised that clients with a different religious orientation to the therapist may be viewed more negatively than those who have a comparable religious stance to the therapist, the result of what Gartner, Harmatz, Hohmann, Larson and Gartner (1990, p.98) call "ideological countertransference". This would be consistent with the finding that those who have a different political view to the therapist are judged more harshly.

Therefore, Bergin (1991) advocates that therapists need to be open about their values, thus allowing clients to take an informed decision before entering psychotherapy. Refusing to acknowledge one's bias as a psychotherapist has the potential to have a negative impact on therapy since remaining silent about one's religious viewpoint is in itself a choice to take a particular value position, and one cannot avoid communicating one's viewpoint during the therapeutic process (Esau, 1998). London (1986, cited in Jones, 1994) suggests that if psychologists were better trained in the field of psychology and religion and had a better understanding of the

critical role that values can play in the process of psychotherapy they would be more willing to be open about their own values in therapy. Jones (1994, p.196) goes on to say that if therapists are less religious than the general population and if therapists' values can impact on their clients' values during therapy "then a cultivated public image of psychotherapeutic practice as a value-neutral enterprise is a misrepresentation of reality". Bias may be an intricate part of all psychotherapy, but is only of concern when it remains unexamined and thus can contaminate the therapeutic process. Bergin (1980a, p.97) suggests that "it is inevitable that the therapist be such a moral agent. The danger is in ignoring that we do this, for then patient, therapist, and community neither agree on goals nor efficiently work toward them".

Walls (1980) argues against being open about one's values as he believes that the mental health profession should not take its cue from the public merely because ninety percent hold a particular belief. Rather he suggests that it is the job of mental health practitioners to be more critical about values and to investigate them more thoroughly. Although this is true, he appears to view psychologists' values as superior to those of the public, a stance criticised by Bergin (1980b) and Corveleyn and Lietauer (1994). Another criticism raised by Tillman (1998) contends that if therapists disclose information about their values too early in the therapeutic process, the client is less likely to be able to explore their own values effectively in therapy. Bergin and Jensen (1990), Halleck (1976) and Jones (1994) cite research indicating that clients' values tend to change during therapy to fall in line with those of the therapist, although it is not clear if this is always a positive change. Consequently, Corveleyn and Lietauer (1994) warn that religious therapists who are open about their values may lead clients towards religion rather than away from it, an area of equal concern.

Although several studies (Houts and Graham, 1986; Lewis and Lewis, 1985; Wadsworth and Checketts, 1980) found that there was no apparent therapist bias towards religious clients, their methodology appears to have been limited, focussing specifically on diagnosis and using only conservative religious groups (Gartner et al., 1990). However, they did find indications that in more intimate interactions between therapists and clients, such

as psychotherapy, religion did form a source of bias. Therefore, clinicians appear to be able to main their neutrality in a structured interaction with the client such as diagnosis, but in assessing their prognosis, motivation for therapy, insight and need for medication and hospitalisation, they appear to be more severe on the religious client (ibid.).

Houts and Graham (1986) further found evidence that clinicians tend to actively target their religious clients' religious beliefs as a factor which they needs to change to become healthier. They also suggest that moderately religious individuals were viewed as more pathological and as having a poorer prognosis than both the very religious and the non-religious individuals. Gartner et al. (1990) found that clients who held a more extreme ideology (whether religious or non-religious) were rated more negatively by the clinicians in their sample. Moreover, Houts and Graham (1986, p.267) cite research by Beutler (1981) which suggests that "clinical judgements are more negative when therapist values and client values are incongruent". It is therefore essential that clinicians acknowledge the interaction between their own religious beliefs (or lack thereof) and their clients'.

Richards and Bergin (1997) and Richards and Potts (1995) advocate the integration of a spiritual strategy in therapeutic interventions with religious patients. Several theorists (Peteet, 1981; Richards and Potts, 1995; Sevensky, 1984; Spero, 1981; Tillman, 1998; Wikstrom, 1994) warn against the potential bias of underestimating pathology in a client with a similar religious stance to the clinician. Galanter et al. (1991) suggest therapists should be cautious about using spiritual strategies in their interventions as this is not taught in official training programmes and may therefore require working outside their area of competency. However, Dishington (1996), Jones (1994) and Richards and Potts (1995) suggest that the client may be best served by a referral to a therapist with similar beliefs. This would potentially help the therapist understand the broad guiding values of the client's religious group providing a degree of religious congruence between therapist and client, a factor that Gartner et al. (1990) see as important to successful therapy.

Worthington (1988, p.171) hypothesised that therapists will only have a negative reaction to a client "if the client's values are outside of the counselor's [sic] zone of toleration". This may explain why some researchers have found bias in therapist and others have not when working with religious clients. Therefore, it may be necessary for a therapist to refer their client to another therapist (or pastoral counsellor) when their zone of tolerance has been breached. If this referral does not occur, it is likely that the therapist will have difficulty in establishing a relationship with the client, diagnose the client more severely and perceive them as less likely to improve unless they change their values to be more consistent with the therapist's.

Shafranske and Maloney (1990) found that a therapist's personal attitude toward religion was a more powerful determinant of the treatment plan they used than their clinical training when working with religious clients, a finding consistent with Bergin's (1980a) theory. The decisions they make about the directions of therapy then impact on the process and outcome of therapy. Worthington (1988), who argues that the religious values of both client and therapist influence the therapeutic process, supports these findings, suggesting that therapists are not able to maintain value neutrality during the course of therapy.

Shafranske and Maloney (1990) found that, despite expectations, nearly three-quarters of the psychologists they surveyed believed that religious issues were within the scope of psychology. However, this must be viewed in the light of their finding that nearly the same proportion were affiliated to an organised religion. Two-thirds of those surveyed also felt that psychologists are not equipped with the skills to address their client's spiritual or religious issues. Over half of this sample believed that it was inappropriate for psychologists to use scriptures in therapy and over two-thirds felt it was inappropriate to pray with a client at any time in therapy. Perhaps even more relevant is their finding that three-quarters of the psychologists interviewed have recommended that a client leave their religion, while only a third had at any stage recommended participation in religion for their clients. They found this was linked more to the therapist's view of religion than their theoretical orientation.

2.2.4.The Ethical obligations of Mental Health workers when working with religious clients

The American Psychological Association (APA) (1992) has much to say about issues relating to the practice of psychology with religious clients in its revised ethical guidelines. Principle D of this ethical code advocates that "Psychologists accord appropriate respect to the fundamental rights, dignity, and worth of all people. ... Psychologists are aware of cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone unfair discriminatory practices." (Ibid., pp.1599-1600). As illustrated in the previous literature, psychologists have not always been true to this principle of the ethical code, particularly with reference to religion, where biases have been common in the past.

Richards and Potts (1995) suggest that ignoring the religious beliefs of the client, as has been quite common in clinical practice, may be a contravention of the ethical principles with regards human diversity (Standard 1.08, APA, 1992). The principle of respect for others (1.09), which suggests psychologists should respect the rights of clients to hold attitudes and beliefs different to their own, and the principle of non-discrimination (1.10) which asserts that psychologists should not unfairly discriminate against their clients on the basis of several factors, including religion, also appear to have been frequently contravened by psychologists working with religious clients in the past. Spero (1981) agrees that therapists are ethically obliged to be professionally detached about the content of therapy and maintain a professional objectivity toward their clients' religious stance, whether it is different or similar to their own. Although it is not possible to be value neutral in therapy, as discussed previously, therapists are ethically obliged to examine the process of therapy and the interaction of their own values and those of their clients. He offers some guidelines that therapists should follow when working with religious clients, such as developing an understanding of what constitutes normal and neurotic religious practice and belief, and the ability to differentiate when clients use religion as a defence and when it represents a mature

response. These are lofty goals considering the lack of training offered by professional programmes on religion, but are nonetheless an important part of the clinician's ethical obligations.

As discussed previously, it is inevitable that there will be some difference between the client's value system and that of the psychologist. If this difference in value systems results in negative value judgements being made by the psychologist, then he or she has contravened the ethical code. Worthington (1988) suggests that if the psychologists' values are outside of their zone of toleration, then they are ethically obliged to refer the client on to someone who is less likely to be at odds with the client. This is congruent with principle 1.20, which asserts that psychologists refer clients on to appropriate sources when it is in the best interests of the client.

Worthington (1988, p.167) further asserts that "influencing clients' religious beliefs - whether toward more or less involvement in religion and whether directly or unintentionally - can have wide ranging effects on their lives". This is an elucidation of principle 1.15 in the APA (1992) ethical guidelines, which stipulates that psychologists should not misuse their influence over their client. One must therefore ask what the ethical obligations of mental health practitioners are towards changing the behaviour of their clients. All psychotherapy, by nature, involves some change, but what areas may psychologists and psychiatrists change?

Dishington (1996) suggests that this creates an ethical paradox, since at present most clinicians are not trained to work sensitively with religious clients and thus focussing on the client's religion may constitute working outside one's area of competency, and working with religion may impose the clinician's values on the client (APA, 1992, principle 1.04, boundaries of competence). However, to ignore clients' religious beliefs is to ignore their diversity and disregards an important part of those clients' personal make up. Therefore Bergin (1980a, p.101) suggests that "It would be honest and ethical to acknowledge that we are implementing our own value systems via our professional work and to be more explicit about what we believe while also respecting the value systems of others".

It becomes evident from this brief examination of the ethical obligations of psychologists that a certain amount of confusion exists on how to treat religious clients. Although the American Psychiatric Association Committee on Psychiatry and Religion (1990) has offered some ethical guidelines for religious clinicians, Richards and Potts (1995) suggest that the ethical guidelines, as they stand at present, are still inadequate with regards to religion. Although psychologists are ethically obliged to respect the rights of their clients to hold different religious beliefs and values from them, they often do not as shall be illustrated in the following sections. It is therefore hypothesised that, despite ethical obligations to be tolerant of client's religious beliefs, they will perceive a religious client as unwell.

2.2.5.Conclusions

McLemore and Court (1977) argue that, when dealing with issues of gender, race, sexual orientation and political affiliation, mental health practitioners have learnt to step lightly, being careful not to upset the apple cart. But with regards religion, they have been rash and intolerant. One can only agree with Bergin's (1980, p. 399) statement that "psychologists' understanding and support of cultural diversity has been exemplary with respect to race, gender, and ethnicity, but the profession's tolerance and empathy has not adequately reached the religious client". This does not preclude discussion of religious issues in psychotherapy, but does call for the therapist to have a degree of empathy and sensitivity for the client's religious beliefs, and to acknowledge the important role that simple faith may play in that client's life (Kroll and Sheehan, 1989).

Spero (1981) argues that the truth may lay somewhere between the initial view in psychology that religion is synonymous with mental illness and the reactionary view that religion is inherently linked to positive mental health. Wherever this truth lies, the mental health practitioner is ethically obliged to be tolerant and respectful of the client's individual differences and preferences with regards religious orientation.

It is also beholden on the author to acknowledge personal biases in the current research. The research was conceptualised around a perception that the mental health profession was negatively biased towards religious clients, something relevant to the researcher based on his past religious involvement.

2.3. Mental health and Religion

2.3.1. Diverse opinions of Mental Health and Religion in the literature

A major point of discussion in the psychological literature concerning religion is whether it contributes to or detracts from mental health. Esau (1998) notes that many of the early psychoanalysts, such as Freud, argued that religious faith was little more than a neurotic coping mechanism. Other famous psychological researchers, such as Leuba and Skinner, agreed with this view (Wulff, 1997). Current psychological literature abounds with studies claiming to show evidence that religion either predisposes one to mental health or alternatively to mental illness. A brief review of some of these views is given below.

A large amount of literature posits a negative relationship between religion and mental health. As mentioned previously in this thesis, Ellis (1980) disputes the contention that religion can offer positive effects on mental health and argues that religious involvement and belief is tantamount to emotional disturbance. His thesis essentially suggests that all strict adherents of any religious body are emotionally disturbed. He continues (without citing relevant literature) to assert that religious believers are dogmatic and therefore inflexible and intolerant. He suggests that people can hold some religious beliefs and be emotionally healthy, although in his opinion this is certainly not the optimal position, if they do not hold the beliefs firmly. He therefore advocates that to help these religious individuals to obtain optimum development, one needs to persuade them to give up their

religious beliefs completely. This article sparked several strong rebuttals in the literature, most notably from Bergin (1980b and 1983).

Bergin responds by acknowledging that there are indeed some unhealthy aspects in religious belief, but condemns Ellis's assertion that all religion is unhealthy as unjustified. He argues that the literature does not supports Ellis's belief that all religion is unhealthy, but suggests instead that there are healthy and unhealthy forms of religious belief. He further argues that mental health practitioners' perceptions of the relationship between religion and mental health as negative are a result of an historical bias against religion by psychology. Guntrip suggested that "to dismiss all religion because there is such a thing as neurotic religion is a dangerous idea, for there are also neurotic forms of politics, art, and marriage" (Tillman, 1998, p.276).

Many researchers argue that religion and mental health are negatively related. Gartner et al. (1990) found that patients with extreme religious beliefs were perceived more negatively by therapists, and were more likely to be diagnosed OCD by mental health practitioners. Research has suggested that religious people are more likely to be prejudiced, emotionally distressed, defensive, anxious and tense, to have excess guilt, poor self esteem, repressed anger, dependency, sexual problems and others (Allport and Ross, 1967; Martin and Nichols, 1962, and Rokeach, 1960, both cited in Bergin, 1983; Schumaker, 1992). Corveleyn and Lietaer (1994) claim that in the field of psychiatry religion is usually ignored and has been less researched in recent decades than in the past. They cite Kaplan and Sadock's (1989) reluctance to mention religion in their *Comprehensive textbook of psychiatry* as evidence of this assertion. Perhaps this is the most honest way for psychiatrists who do not understand religion to respond.

However, others have put forward persuasive arguments for a positive relationship between mental health and religion (Gartner, Larson and Allen, 1991; Jones, 1994; Lindenthal et al., 1970 cited in Bergin, 1983; Littlewood and Lipsedge, 1997; Shaver et al., 1980; Stark, 1971). Richards et al. (1989) suggest that strong religious belief

is negatively associated with many anti-social behaviours such as drug abuse, alcoholism, and delinquency. Allport and Ross (1967), in contrast to previous researchers, note that individuals who attend church frequently are less prejudiced than individuals who do not attend services or rarely attend services. Schumaker (1992) suggests that religious belief can decrease levels of anxiety, offer a sense off hope and purpose for life, help to establish moral guidelines, promote social cohesion and a social identity.

Moomal (1999) argues that participation in religion may have evolutionary benefits by decreasing anxiety. From this perspective, religion has survived for thousands of years because of the adaptive advantage it offers to its participants. Galanter and Buckley (1978) even submit that religious conversion may serve as an alternative from decompensation for patients faced with a crisis. Other studies have also found a positive relationship between religion and physical health (McIntosh and Spilka, 1990, in Bergin, 1991), a finding endorsed by Argyle and Beit-Hallahmi (1975).

In an effort to understand this contrasting literature, Larson et al. (1992) conducted a study into articles with religious content in the *American Journal of Psychiatry* and *Archives of General Psychiatry* over the period 1978 to 1989. They found that overall religious beliefs tended to be beneficial for mental health. They specified four aspects of religious practice that they felt were shown across the literature to lead to positive mental health. These aspects were (1) Ceremony; (2) Social support; (3) Prayer; and (4) Relationship with God. Two other aspects which they identified, (5) Meaning and (6) "Indeterminate" or unspecified, were found to have both positive and negative effects on mental health.

They cite a similar study conducted by Gartner et al. (1991) in which they found that studies of non clinical populations using measures of psychopathology (a questionable research technique at best) found religion to have a neutral or harmful role more often than a positive one. However, they found that amongst clinical populations, religious commitment tended to have a beneficial role more than a harmful role. Bergin's (1983)

metanalysis of research found that 23% of the studies manifested a negative relationship between religion and mental health, while 47% showed a positive relationship.

Bergin, Stinchfield, Gaskin, Masters and Sullivan (1988) found in a group of Mormon subjects that continuous religious development (a process whereby religion has been constantly relevant to the person over a long space of time) and a mild religious experience (as opposed to an intense, emotional experience) had a positive impact on mental heath. In contrast, those with a sporadic and interrupted religious development and a tendency to use their religion as a means of obtaining status, security and sociability tended to find more negative impacts on mental health. Many other researchers have also noted the contrasting results in the literature and concluded that the current definitions and perceptions of religion and mental health are inadequate (Argyle and Beit-Hallahmi, 1975; Dishington, 1996; Richards et al., 1989; Schumaker, 1992). Richards and Bergin (1997, p.78) claim that "there are diverse, broadly defined measures of both religiousness and mental functioning. When so many inconsistently defined indexes of religion and pathology are correlated in different studies, they have yielded different results".

It must also be noted that the majority of the research investigating religious belief and mental health focused on simple correlational studies and one cannot draw causal links from these studies. Larson et al. (1986) conducted a meta-analysis of psychiatric research into religion and found that over half of the studies involving religion involved only descriptive statistics, a significantly higher proportion than in other articles. They also found that 83% used only a single question about religion, with only 3% of articles aiming to investigate religion using more than two questions to investigate the subject. Finally, they also found that in 83% of the articles surveyed they had no references to any previous religious research and only 10% had more than two such references.

Wulff (1997) suggests that this may be exacerbated by the agendas of people investigating the topic. Thus, he argues that researchers with a negative conception of religion will set up studies that will find negative

relationships between mental health and religion and those positively predisposed to religion will set up studies showing positive relationships between religion and mental health. Bergin (1983) also suggests that two researchers with different views of religion will view the same behaviour in a completely different light. Therefore "one researcher views a worshipful life-style positively in terms of reverence, humility and constructive obedience to universal moral laws, whereas another researcher views the same lifestyle negatively, as self-abasing, unprogressive, and blindly conforming" (Bergin, 1983, p.174). Several authors claim that it is not uncommon to hear therapists exhorting their client's to give up some or all of their religious beliefs even though the beliefs have little impact on the issues before them (Bergin and Jensen, 1990; Dishington, 1996; London, 1976). Bergin (1991) also suggests that researchers choose the results from the literature that agree with their hypotheses and disregard the contrasting results as irrelevant or of poor methodological standing.

Thus, it becomes evident from the literature that it is inadequate to make sweeping statements of the associations between religion and mental health. A comprehensive perusal of the relevant literature highlights the methodological inadequacies and the limited definitions of religion often evident in psychological research (Richards et al., 1989). Consequently, the field needs more rigorous and statistically powerful research to determine the true relationship between mental health or illness and religious belief. Recent research into the field suggests that religion is not a simple, one-dimensional factor, but may well be a multifaceted entity.

2.3.2.A furore in the literature - the research of Cohen and Smith

An illustration from the literature of the debate over religious issues follows the publication of a case study by Cohen and Smith (1976). They presented the case of Mary, a twenty-eight year old Christian Science woman, who presented with obsessive behaviours. Although they gave little background information, thus rendering it impossible to adequately criticise their diagnoses, they asserted that Mary's religious beliefs had led to the

development of her obsessive behaviours. Therefore, their focus of treatment was to get Mary to alter her beliefs and they report that after so doing she was healed of her psychological problems.

The resulting furore in the literature indicated the strong feelings that the topic of psychopathology and religion evokes. London (1976) argues that, although it is possible for religion and psychopathology to go hand in hand, Cohen and Smith offer no definitive proof that this is the case with Mary. They suggest that Mary's religious beliefs are unlikely to have caused her obsessive behaviour as she was not actively involved in the religion for an extensive period of time. In this they concur with Witzum, Greenberg and Buchbinder's (1990) belief that religion may be less a cause of pathological behaviour than an avenue for expression of this behaviour. McLemore and Court (1977) point out that Cohen and Smith dismiss the positive aspects of Mary's religious involvement, such as her ability to quit smoking after having smoked three packs a day. Therefore, London (1976) argues that, although there may well be occasions when the therapists may be required to advocate a change in religious beliefs, they must first acknowledge their biases and be open about these with the client.

Halleck (1976) suggests that it is a farce for therapists to claim that they are neutral in therapy, and consequently Cohen and Smith cannot legitimately claim that they were value neutral in their therapeutic treatment of Mary. He suggests that it is not unusual for any client to have a change of belief structure in therapy, for this is the very nature of therapy. However, if therapists are open about their value systems, they can empower the client to choose the therapist most suited to their belief system. Further, he suggests that it is likely that Mary had already made a conscious decision to move away from the Christian Science religion as she was well aware that the religion does not permit it's believers to consult secular health practitioners. Coyne (1976, p. 1016) takes this argument even further and suggests that little research has been conducted into the "untoward, second-order effects" that psychotherapy may have on a client, thus making it very difficult to keep one's clients truly informed of the possible outcomes of seeking therapy with one. One of these second-order effects in Mary's case may well have been the loss of her belief system.

Finally, McLemore and Court (1977) argue that Cohen and Smith posed only one alternative to Mary, that of atheism. They suggest that this is in essence abusing the power of the psychotherapeutic relationship to convey one's own belief system into another's life. They suggest that when working with religion, a therapist needs to be as sensitive to the possibility of changing this as they would be with regards a client's sexual orientation or political affiliations, no matter how adaptive or pathological they may be. They further argue that even apparently bizarre religious beliefs may be functional in some situations, and mental health practitioners are ethically obliged to thoroughly consider and investigate the potential benefit of such beliefs before summarily dismissing them as irrational and pathological. Wakefield (1992) also argues that for a therapist to diagnose an individual's behaviour as a disorder, they must display behaviour that is both harmful and dysfunctional. This argument will be elaborated on in section 2.3.4.

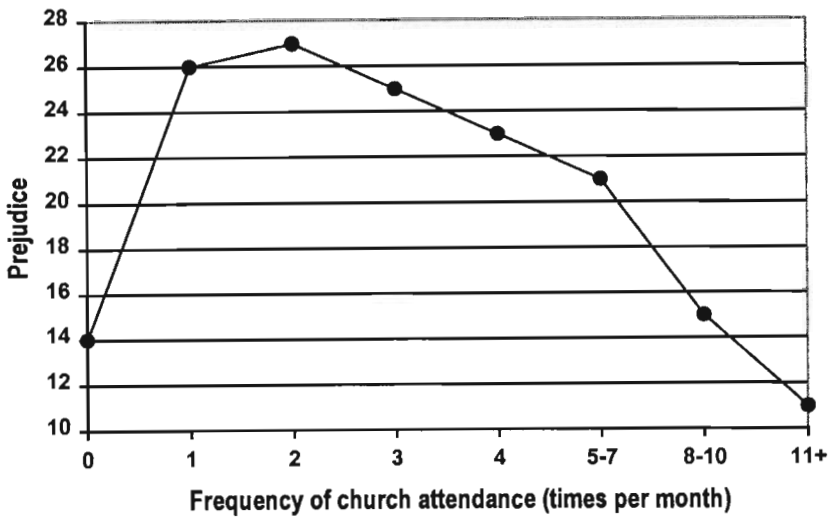
2.3.3.A synthesis: Different ways of being religious

The previous examination of the literature reveals that a perception of religion as a homogenous entity is unrealistic. Richards et al. (1989, p.507) suggest instead that religion is a "complex, multidimensional phenomenon". Allport and Ross (1967) suggested that there was a curvilinear relationship between church attendance and prejudice. This curvilinear relationship, illustrated in figure 2, implied that those who never attended church and those who attended church very frequently were found to be less prejudiced than those who attended church only two or three times a month. This curvilinear relationship appears to explain some of the inconsistent findings reflected in the psychological literature when investigating religion.

Allport and Ross (1967) suggested that this could be attributed to the religious motivation of those attending church. They argued that those who scored low on prejudice were *intrinsically* religious, whereas those who scored high on prejudice were *extrinsically* religious. Richards and Bergin (1997) define intrinsic religion as an

internalised belief, which is lived regardless of the consequences of that belief and is characterised by unselfish commitment to the religion, in which the religion itself acts as a satisfactory end. In contrast, they suggest that extrinsic religious belief is a selfish and utilitarian faith that uses religion as a means to obtain status, security, sociability and self-justification.

Figure 2: Church Attendance vs. Prejudice (Wulff, 1991, p.221).



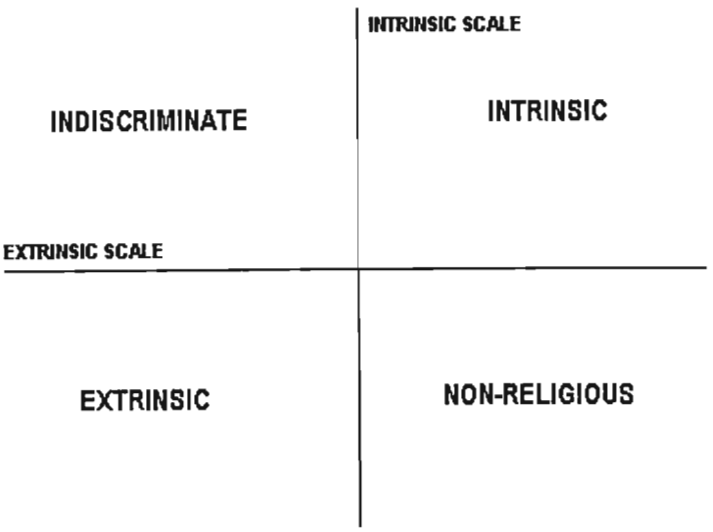
Allport set out to find a way of measuring extrinsic and intrinsic religion. He set up a 21-item scale to examine the concepts. Feagin (1964, cited in Donahue, 1985) noted from a factor analysis of the responses of a group of Southern Baptists, that intrinsic and extrinsic religion did not appear to be opposite of one another. Instead, they appear to be to separate and discrete scales. From this factor analysis he set up a 12-item scale with six items measuring each scale (Wulff, 1991). Allport and Ross (1967) used 20 of their original 21 items to form the Religious Orientation Scale (ROS) which measures intrinsic and extrinsic religion as discrete scales. Allport and Ross (1967) also noted that there are interactions between the two scales, with some people agreeing to items on both scales while other disagreeing with all the items. Therefore, they suggested a fourfold typology based on the responses to the ROS (Donahue, 1985, p.401):

- Those who agreed with items on the *I* scale and disagreed with items on the *E* scale he called *intrinsics.*
- Those who disagreed with items on the *I* scale and agreed with items on the *E* scale he called *extrinsics.*
- Those who agreed with items on both scales he called *indiscriminately proreligious* (or *indiscriminate*).

- Those who disagreed with items on both scales he called *indiscriminately antireligious* (or *non-religious*).

These are illustrated below in figure 3.

Figure 3: A graphic representation of Allport's fourfold typology.



Donahue (1985, p.400) suggests that "no approach to religiousness has had greater impact on the empirical psychology of religion than Gordon W. Allport's concepts of intrinsic (*I*) and extrinsic (*E*) religiousness". Allport's ROS is one of the most frequently used measures of religiousness. As a result there is a large body of research into the ROS. Donahue reviews some of this research and suggests that the concepts are most discrete for respondents that have some sort of religious affiliation or interest in religion. *I* and *E* show markedly different relationships with other measures of religiousness. Donahue cites six studies in which intrinsic religiousness correlates .39 with religious orthodoxy, while extrinsic religiousness only correlates .16 with the same measures. When correlated with respondent's ratings of the importance of religion, *I* correlated .76, whilst *E* correlated only .03. Donahue suggests that this does not make extrinsic religiousness an invalid concept, but rather confirms Allport's definition of extrinsic religion as a utilitarian faith that uses religion as a means to obtain status, security, sociability and self-justification.

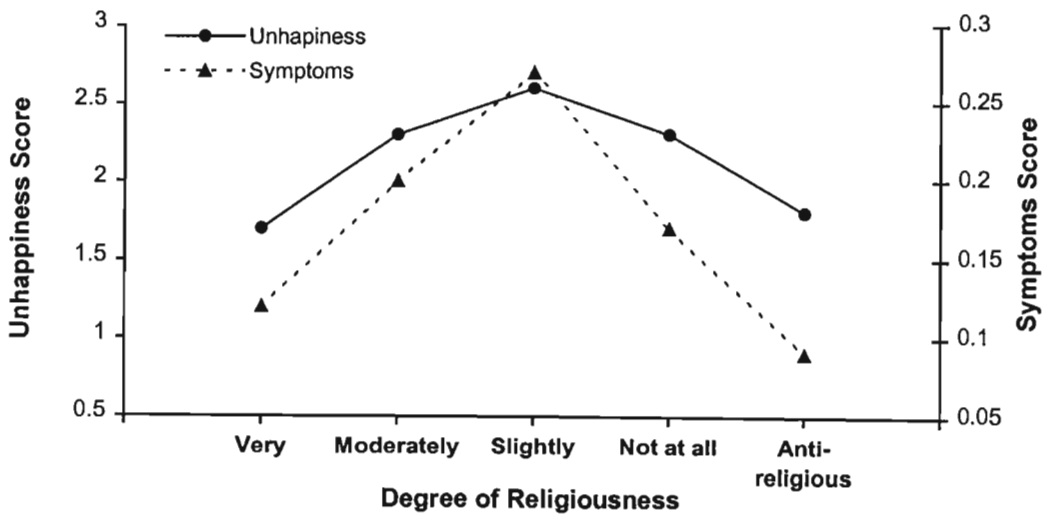
Other studies have also examined correlations of *I* and *E* with other measures. Donahue (1985) cites research indicating that *I* is either negatively correlated or uncorrelated with prejudice, while *E* is positively correlated with prejudice. Fear of death may also be negatively correlated with *I* while positively correlated with *E*. Donahue also cites internal locus of control and purpose in life as positive correlates of intrinsic religiousness, while trait anxiety and perceived powerlessness are negatively correlated with *I* and positively correlated with *E*. Richards and Bergin (1997) and Bergin et al. (1988) argue that intrinsically motivated religiousness produces positive effects on mental health whereas extrinsic religiousness produces negative effects on mental health. Bergin (1991), who found that intrinsic religiousness was negatively correlated with pathology while extrinsic religiousness was positively correlated with it, confirms this assertion. Smith (1998) suggests that, although intrinsic religiousness may not prevent psychological problems, it appears to be a positive therapeutic influence if discerned by the therapist. Bergin et al. (1987) also concluded that intrinsic religiousness is positively associated with personal adjustment, less anxiety, self-control, freedom from self-doubt, tolerance, social maturity, and responsibility. Extrinsic religiousness by contrast was negatively associated with many of these factors. Bergin et al. however note that their results do not show a causal pattern. Consequently, one cannot say that intrinsic religiousness causes good personal adjustment, since it may be that a well-adjusted person is more likely to become intrinsically religious.

Research using the fourfold typology instead of the simple concepts of intrinsic and extrinsic religion yields further interesting results. Although the research is not unanimous across the literature, Donahue (1985, p.409) suggests that there is a general trend for the relationships between prejudice and dogmatism and the four typologies. He suggests that the order is intrinsic = non-religious < extrinsic < indiscriminate. This implies that indiscriminately religious people are most likely to be prejudiced, whilst the intrinsically religious and non-religious are least likely to be prejudiced. Allport and Ross (1967) also found a highly significant relationship to prejudice such that intrinsic < extrinsic < indiscriminate. They suggest that this may be an indication that those who require support and social approval through their religiousness are more likely to require prejudiced views to support

their psychic structure, while those who are intrinsically religious have no place in their lives for rejection and prejudice.

Shaver et al. (1980) investigated religiousness and its relationship with several mental and physical symptoms and unhappiness. The results of this study are shown in figure 4 below. An inverted U pattern was found with the very religious and the anti-religious having fewer symptoms and less unhappiness than the other categories. This result was found to be highly significant when tested with an ANOVA. Shaver et al. suggest that this indicates that religious ambivalence has negative mental and physical consequences.

Figure 4: Relationship between degree of religiousness and general unhappiness; and between religiousness and physical and mental symptoms among 2,500 American women (Shaver et al., 1980, p.1567).



Despite the widespread use of the ROS, there have been several criticisms of the scale. Donahue (1985) suggests that one of the major criticisms of the instrument is the lack of standardisation in its administration and scoring. He advocates that bipolar scoring of the scales be abandoned, each item be scored from 1 to 5, and for the median splits of *I* and *E* be based on the theoretical midpoints of the scales (27 and 33 respectively). Another criticism of the instrument is that it is not suitable for non-religious respondents.

Batson and Ventis (1976, cited in Donahue, 1985) offer some further criticisms of Allport's concepts of intrinsic and extrinsic religion. Batson and Ventis's criticism is based on their belief that doubt is an essential part of mature faith. They suggest that Allport has excluded that element from his concept of intrinsic religiousness and therefore proposed an alternative instrument, the Religious Life Inventory (RLI). The RLI has three scales: the *external* (similar to the ROS's extrinsic); the *internal* (measuring one's need for religion); and the *quest (Q)* scale (measuring those who question life's meaning without belonging to a formal religious group).

Despite initial successes by Batson and his colleagues in testing the Q scale, Donahue notes several criticisms of the concept. Firstly, Batson claimed that the Q concept was consistent with religious traditions such as the Hebrew prophets. Closer examination suggests that this is not true. The prophets were aligned with a religious tradition and did not question so much as challenge the believers of the time. Secondly, Batson argues that Allport viewed doubt as the master motive of mature faith, but a closer reading of Allport suggests that he simply viewed doubt as a refining fire for faith. Thirdly, and most importantly, there is no evidence of any construct validity for the concept of Q. Donahue argues that it has never correlated with any scale of religiousness, and appears instead to measure agnosticism. Fourthly, Donahue criticises the methodology used by Batson in testing his concept. He often used samples of less than 50, conducted most of his research with college students, a group well known for religious questioning, and has only done research with those who ranked their religiousness as more than 4 out of 10, thus truncating the range of individuals responding to the questionnaire. Further criticisms include the statistical analysis of his data.

Although these criticisms suggest that further research needs to be conducted into the quest variable before it can be adequately used in the literature, Batson has made an important contribution to the debate around religiousness. Allport and Ross (1967, p.442) conclude that "to know that a person is in some sense "religious" is not as important as to know the role religion plays in the economy of his life". Therefore, the ROS continues to be the instrument of choice at present for measuring religiousness. The fourfold typology offers a very useful tool

for researchers to be able to distinguish between what William James calls "healthy minded religion" and the "sick soul" (Bergin, 1991). Bergin et al. (1987, p. 201) suggest that "the differentiation of religion into *I* and *E* orientations ... makes more meaningful the conclusions that may be drawn regarding religion and its relation to mental health".

2.3.4.Psychopathology and Religion

When one considers the above literature, it is interesting to note that there is relatively little sound research in the literature on religion and mental illness. Richards and Bergin (1997) suggest that the lack of research into mental health and religion is a result of researchers focussing on college students as an easy and accessible sample. Here, as with previously mentioned literature regarding religion, the results appear to contradict each other.

Those in the field of psychology who argue that religion has negative effects on mental health have often suggested that the biblical saints and prophets have suffered from various mental disorders. It has been suggested that Saint Paul was epileptic, thus explaining his revelatory experiences on the road to Damascus and many of the prophets such as John the Baptist were psychotic. "Joan of Arc has been diagnosed as Lesbian, transvestite, schizophrenic, paranoid, creative psychopath, hysteric and epileptic" (Argyle and Beit-Hallahmi, 1975, p.136). Littlewood (1998) however, argues that this is not a new phenomenon. He suggests that the Hebrews attempted to discredit some of their prophets by suggesting they were insane. Likewise, governments have condemned members of various religions to asylums. In the 1930s Jehovah's Witnesses were placed in asylums, as were Baptists and Pentecostals in contemporary Russia (ibid.).

Argyle and Beit-Hallahmi (1975) cite research suggesting that several religious denominations appear to be more predisposed to certain disorders than the general population. They suggest that Catholics were 40% more likely to have an alcoholic psychosis and slightly more likely to have schizophrenia than the general population. Jews

were 144% more likely to have a "neurosis" and 69% more likely to have manic depression. They do however suggest that one should take social factors, such as income and social class, into consideration when attempting to understand these figures. It is possible that Catholics are over represented in the lower social classes and lower income groups, thus placing them at increased risk for alcoholism and schizophrenia. Similarly, Jews belong mainly to the upper and middle class and have a history of persecution and this may explain their predisposition to neuroses. It is therefore not possible to directly attribute the pathology to religion, but perhaps instead to the social factors associated with those religious groups.

Argyle and Beit-Hallahmi (1975) note that clinical studies have found no difference between the mental health of Pentecostal or Charismatic church members and those in the general population. Likewise, Lewis and Lewis (1985) found that the religious orientation of both client and therapist was not related to any tendency to ascribe diagnostic labels. Yet a perception continues to exist amongst mental health workers that membership of a Pentecostal church will predispose one to poor mental health (Littlewood and Lipsedge,1997; Littlewood, 1998). Lewis and Lewis's concurs with these findings by asserting that religious bias is least evident in formal diagnoses, but becomes apparent in the therapist's opinions of the role religion plays in clients' difficulties and in their interactions with their clients.

Richards and Bergin (1997) note that there is some indication that people with psychosis and depression are less likely to be involved in organised religion, but this may be attributable to the social aspects of the specific disorders. Littlewood and Lipsedge (1997) suggest that church membership is associated with better mental health, although the direction of causation is unclear in this relationship. Larson et al. (1992) suggest that not only is there little relationship between religiousness and psychopathology, but there appears to be a strong positive association between religiousness and mental health, a belief shared by Jones (1994). Houts and Graham (1986) found that moderately religious clients were more likely to have psychopathology than very

religious clients and non-religious clients. This is consistent with the findings of intrinsic and extrinsic religion and may again explain some of the discrepancies in the literature with regards psychopathology and religion.

Littlewood (1998, p.131) quotes Wilson (1975) as saying "if a man runs naked down the street proclaiming that he alone can save others from impending doom, and if he immediately wins a following, then he is a charismatic leader ... If he does not win a following, then he is simply a lunatic ... The very content of "plausability" is culturally determined". Sevensky (1984) suggests that it is quite feasible that some of the prophets and religious leaders of various religions throughout history had mental illness, but argues that one could argue theologically that God works through nature (in all its forms), not in spite of it.

Greenberg (1984) reviewed several cases of Jewish clients who presented with forms of psychopathology. He suggested that one should liase with the Rabbi (or relevant religious authority) to discover whether the behaviour is normal for their "cultural" or religious group. This would facilitate a more holistic understanding of the client's issues and the best way forward. Therefore, it is hypothesised that mental health practitioners who are most likely to have an effective understanding of a religious client whose beliefs differ from theirs, should consult with a religious authority on the client's symptoms.

The argument that an individual must deviate from the dominant norms of society to be diagnosed as having a mental disorder is put forward by the DSM IV (APA, 1994). Wakefield (1992) suggests that even this is insufficient. He asserts that, for an individual to be diagnosed with a mental disorder, the therapist must be able to show that the individual's behaviour is both dysfunctional and harmful. It is not enough for the behaviour merely to be dysfunctional without any harmful effects. Thus, if an individual has visions and hears voices, but has no negative or harmful effects, they cannot be diagnosed with a psychotic mental disorder. Wakefield argues that, although the DSM IV (APA, 1994) contends that its diagnostic criteria meet the requirements for both dysfunctional and harmful behaviour, they often fall short in adequately meeting the criterion of harmful

behaviour. He suggests that this lack of sufficient criteria for harmful behaviour may lead to patients being over diagnosed with disorders, when their behaviour causes them and those around them little or no harm. Wakefield also acknowledges that an assessment of harmful effects depends on value judgements from the therapist. (ibid.) Consequently, these therapists should liase with members of the individual's community to ensure a minimum of bias in their assessments of whether the behaviour is harmful or not.

Littlewood and Lipsedge (1997) suggest that the cultural differences between patient and doctor (or psychologist) are often ignored by the doctor. They claim that the doctor's position of authority forces the patient to conform to the doctor's viewpoint before he is considered "healthy" again. If the patient holds to his religious beliefs, the doctor says that he has no insight and "sentences" him to higher doses of medication. Although somewhat extreme, this example serves to illustrate the importance for clinicians to examine their biases and value judgements. Littlewood and Lipsedge argue that mental health is based on concepts of normality, which differ from culture to culture. Consequently, mental health practitioners need to be aware of their worldview, and how it interacts with the worldview of the clients.

An area of special interest in this research is the area of religious psychosis. Many authors note that psychotic symptoms are frequently associated with hyper-religiosity, yet little consideration is given to the cultural appropriateness of these symptoms. This will therefore be discussed in the following section.

2.3.5.Religious Psychosis?

The absence of literature with regards to schizophrenia and religion is even more surprising in light of the fact that the disorder is one of the most common seen in inpatient wards of hospitals (Boyle, 1997) and that it not infrequently has patients who present as hyper-religious. However, Witzum et al. (1990) investigate the relationship between Bratslav Hasidism and schizophrenia. They discuss the Bratslav Hasidism sect in

Jerusalem and the interesting finding that schizophrenia appears to be diagnosed five times more frequently in Bratslav Hasidism than other clinic referrals and thirty times more often than the general population. They suggested that this is not an indication that the religion produces psychosis in individuals, but rather that individuals predisposed to schizophrenia may be attracted to Bratslav Hasidism. They suggest that "their psychotic isolation found a socially acceptable form in nocturnal meditation in the fields and at the graves of zaddikim [spiritual leaders], and their bizarre behaviour could be explained as an acceptable expression of distress" (Witzum et al., 1990, Pg. 127). Brewerton (1994) also proposes that an individual's upbringing will influence how his psychosis will present. Thus, a person who has a religious background is more likely to display religious symptoms in any disorder.

The concept of schizophrenia has changed dramatically since the 1960s and has gradually been defined more carefully in the literature. The advent of the DSM III (American Psychiatric Association (APA), 1980) and more recently the DSM IV (APA, 1994) have increasingly specified more concrete definitions for the diagnosis of schizophrenia. Included in the DSM III was a note on diagnosis as follows: "Beliefs or experiences of members of religious or other subcultural groups may be difficult to distinguish from delusions or hallucinations. When such experiences are shared and accepted by a subcultural group they should not be considered evidence of psychosis" (APA, 1980, Pg. 188).

The DSM IV further notes that clinicians must be aware that ideas that may appear to be delusional in one culture may be commonly held in another culture. Similarly, it may be normal religious experience in one's culture to experience visual or auditory hallucinations, such as "seeing the Virgin Mary or hearing God's voice" (APA, 1994, Pg. 281). These would therefore not be considered symptoms of schizophrenia, but culturally appropriate phenomena.

Therefore Witzum et al. (1990) attempt to differentiate between what are normal features of Bratslav Hasidism and what are abnormal. They suggested two main features that differentiated psychotics from normal Bratslav Hasidism followers, the first of which was a recent process of change. Thus a patient may have once conversed and studied frequently with others, but became isolated and avoided contact with others. The second indication was an emphasis on 'fringe' religious practices, such as focussing on reciting psalms, while they neglect the main religious routines of prayer and cleanliness.

Witzum et al. however, state that it is somewhat more difficult to differentiate between hallucinations and delusions and the culturally held beliefs of their sect. They site Murphy's (1967) explanation that sometimes "the only distinction is in the intensity with which the belief is held" (cited in Witzum et al., 1990, Pg. 128). Thus, they were unable to offer a solid base on which to discriminate between hallucinations and delusions and culturally appropriate beliefs.

Littlewood and Lipsedge (1997) also cite religious experiences in Pentecostal Christians, which appear to be very similar to psychotic symptoms, such as the feeling of being controlled by God and speaking in tongues. However, they contend that these religious experiences are different from psychosis because they are considered normal by the individual's group and are usually of benefit rather than of harm to him or her. They suggest that congregations usually identify genuinely psychotic patients as such because they are not able to control their behaviour in such a way as to conform to the rituals of the church. Wakefield's (1992) contention that an individual's behaviour must be harmful before it can be considered a disorder support these arguments by Littlewood and Lipsedge (1997).

Boyle (1997) asserts that it is more important to ask what is the function of religious delusions and hallucinations. This has been largely ignored in past research but Boyle suggests that these hallucinations may prove comforting and help to stabilise the patient's world. Littlewood and Lipsedge (1997) note that in some religious

contexts visions from God and hearing God's voice are commonplace and even expected of the congregations. Boyle (1997) further suggests that what mental health professionals describe as delusions may be simply regular beliefs. She argues that a definition of delusion as a belief in the impossible held with absolute conviction, describes normal religious faith. As such, there is very little to differentiate psychotic delusions and normal religious beliefs, which many in the field of mental health would believe to be fanciful and impossible.

The DSM IV suggests that to ascertain whether the patient's behaviours are pathological, one should compare them to others within their cultural setting, a suggestion endorsed by Greenberg (1984). Foucault also agrees with this assertion when he states: "religious delusions is a function of the secularization [sic] of culture: religion may be the object of delusional belief insofar as the culture of a group no longer permits the assimilation of religious or mystical beliefs in the present context of experience" (Foucault, 1962, cited in Carette, 1999). Despite these clear mandates from the diagnostic guidelines for psychology and psychiatry, clinicians still appear to be unaware of what constitutes different cultures, and religion appears to be an area of culture frequently ignored. It is therefore hypothesised in this research that clinicians will allocate a diagnosis to clients who have religious delusions and visions, despite them being considered culturally appropriate by their own religious group.

Therefore, this study investigates how a group of psychiatrists, a group of psychologists and a group of ministers of religion assess the same fictional case study. The case study is of a man who would meet the diagnosis of a schizophrenic disorder if his symptoms were not deemed "culturally appropriate".

3. DESIGN AND METHODOLOGY

3.1. Aims/ Rationale

As discussed in the introduction and again in the literature review, this study has two main aims.

1. The first aim of the study is to compare mental health practitioners and ministers of religion in their tendency to evaluate religious experience as either a manifestation of religious commitment or psychopathology. The study does this by investigating the differences between mental health workers and ministers of religion in their impressions of a religious client. These impressions include the nature and diagnosis of the client's difficulties, assessment of the client's degree of impairment, assessment of the important variables in healing a client, assessment of the most beneficial mode of treatment for the client and assessment of the role played by the client's religious beliefs in any problems.

The rationale for this aim flows from the above literature review. The literature has illustrated a tendency for mental health practitioners to view religious clients as more disturbed and as having a worse prognosis than comparable non-religious clients. It has also highlighted a potential bias by mental health practitioners against their religious clients. The literature further illustrates the potential for psychologists and psychiatrists to incorrectly diagnose religious behaviours as symptoms of disorder. The DSM IV (APA, 1994) suggests that it is important to ensure that behaviours exhibited by clients are not culturally appropriate if one wishes to diagnose them as symptoms of a disorder.

Despite this criterion for diagnosis and the arguments in the literature against bias, the literature does not appear to have compared the views of psychologists or psychiatrists with the views of ministers of religion on what constitutes religious belief as opposed to mental illness. Therefore, this study seeks to investigate whether

mental health practitioners are more inclined than ministers of religion to interpret unusual religious belief and experience as mental illness.

2. The second aim of this study is to investigate whether the mental health practitioners' religious beliefs impact on their mental health practice, such as diagnosis of clients, assessment of the client's degree of impairment, their assessment of the most beneficial mode of treatment for the client and their assessment of the role played by the client's religious beliefs in any problems.

The rationale for this aim follows from the above literature that argues that psychologists and psychiatrists have lower levels of religious affiliation than the general population, and may therefore be biased against their religious clients. The literature suggests that levels of religious affiliation, and levels of bias, may be different for psychologists and psychiatrists. Consequently, groups of psychologists and psychiatrists have been included in this study.

The literature described above is not unanimous in its assessments of whether mental health practitioners' religious affiliations and beliefs do influence their assessments of religious clients. Therefore, this study aims to add to this controversial body of research by investigating the role played by the religious beliefs of South African psychologists and psychiatrists in their assessments of a religious client.

Therefore, the study investigates mental health practitioners' religious orientation (as discussed by Allport and Ross, 1967; Donahue, 1985; Wulff, 1991), their religious affiliation and their self professed degree of religious belief. The impact of religious variables on: the nature and diagnosis of the client's difficulties, assessment of the client's degree of impairment, assessment of the important variables in healing a client, assessment of the most beneficial mode of treatment for the client and assessment of the role played by the client's religious beliefs in any problems was examined.

3.2. Hypotheses

To address these aims as outlined above, the following hypotheses have been identified. There are two main hypotheses each with the same six sub-components.

Hypothesis 1: There is a difference between mental health practitioners (psychologists and psychiatrists) and ministers of religion in their assessment of religious clients.

Hypothesis 2: There is a difference between mental health practitioners (psychologists and psychiatrists) of differing religious orientation and degrees of religious belief in their assessments of a religious client.

It is hypothesised that the differences identified in the two hypotheses above in their assessments of a religious client will be manifest in six different areas:

a) In their assessments of a client's religious and psychological experience and the problems facing a religious client.
b) In their assessment of the people whom they consider the most appropriate to treat or intervene with a religious client.
c) In their assessment of the most beneficial mode of treatment for a religious client.
d) In their assessment of the degree of mental health impairment of a religious client.
e) In their perceptions of the important variables in healing a religious client with mental health problems.
f) In their perception of the role of religious beliefs in the causation and treatment of a client with problems.

3.3. Subjects

The subjects for this study were selected to address the aims set out in section 3.1. The first aim of the study was to investigate the differences between the views of mental health practitioners and the views of ministers of religion in their assessment of a religious client, while the second aim of the study was to investigate the differences between mental health practitioners of differing religious orientations in their assessment of the same client. Thus, a group of psychologists and psychiatrists was required to address both the first and second aims of this study. A list of psychologists in private practice in the Pietermaritzburg area and a list of psychologists working in psychiatric hospitals in Pietermaritzburg were used to select the psychologist group. All the psychologists from these lists were contacted and asked to participate in the study. A list of psychiatrists working in the Pietermaritzburg area was obtained from a psychiatric hospital in the Natal Midlands. Again, all the psychiatrists on the list were asked to participate in the study.

It was decided to include only Christian ministers of religion in the sample, since most of the literature reviewed deals with the assessment of individuals form a Western, and thus predominately Christian, background to address the first aim of the study. To ensure that a wide range of religious belief was covered ministers from traditional or mainstream Christian churches and ministers from Pentecostal or Charismatic Christian churches were included in the sample.

An initial list of mainstream Christian churches in the Pietermaritzburg area was obtained from the School of Theology, University of Natal. More information was obtained from the Church of the Ascension and St. Matthews Church. A list of Pentecostal Christian churches in the Pietermaritzburg area was obtained from New Covenant Fellowship in Pietermaritzburg. All the ministers obtained from these lists were contacted and asked to participate in the study.

Seventy seven percent of the potential subjects from the lists above initially agreed to participate in the study. This percentage was different for the different subject groups. Approximately two thirds of the Pentecostal ministers agreed to participate, while more than four-fifths of the Mainstream ministers and psychologists agreed to complete the questionnaire. Nine-tenths of the psychiatrists also indicated that they would complete the questionnaire. However, only 53% of those identified as potential subjects from the lists returned the questionnaire. The drop out rates and total group sizes are reflected in table 1. The lowest response rate was found amongst the Pentecostal ministers and Psychiatrists, where only 47% of those identified as potential subjects returned the questionnaire. The high drop out rates by psychiatrists and Pentecostal ministers means that these two groups contain less subjects than the psychologist and mainstream minister groups. Refer to section 4.1.1 for further demographic details of the sample.

Table 1: Response Rates of Subjects

Group	Initially Contacted	Completed Questionnaires	Response Rate
Pentecostal Ministers	28	13	47%
Mainstream Ministers	27	17	63%
Psychologists	35	19	54%
Psychiatrists	19	9	47%
Ministers of religion	55	30	60%
Mental Health Practitioners	54	28	52%
Total	**109**	**58**	**53%**

3.4. Instruments

The study used three tools, which were self-administered. They were as follows:

3.4.1.Hypothetical Case Study

A fictional case study of John (hereafter referred to as "the client") was set up to have ambiguous religious aspects to it, which might be interpreted as psychopathology or religious devotions. The case was deliberately set up to meet the diagnostic criteria for schizophrenia, provided that the mental health practitioner did not consider the client's "hallucinations" and "delusions" to be culturally appropriate behaviour, as suggested in the DSM IV (APA, 1994). Although several authors were reviewed (Spitzer, Skodol, Gibbon and Williams, 1981; Oltmanns, Neale and Davison, 1995), no existing case study was found with a satisfactorily ambiguous religious nature in the literature. Consequently, a hypothetical case study was formed based on the guidelines of other case studies presented by Spitzer et al. (1981) and Oltmanns et al. (1995).

Since the case study was to be the same for both mental health practitioners and ministers of religion, it was constructed without excessive reference to psychological language. It sets out a brief history of the client, a review of his current behaviour and concludes with a brief mental status examination. See Appendix A for a copy of this case study.

3.4.2.Questionnaire on Case Study

A questionnaire was constructed to investigate the respondents' assessments of the hypothetical case study (Appendix B). The questionnaire attempts to identify the six major dependent variables to be used in this study. These are:

- The type and nature of the client's problem including a diagnosis of any problems

- The most appropriate person to treat the client
- The most beneficial mode of treatment for a religious client.
- The degree of mental health impairment of a religious client.
- The important variables in healing a religious client with mental health problems.
- The role of religious beliefs in the causation and treatment of a client with problems.

The questionnaire uses specific questions from research conducted by Liebenberg (1992) and Lewis and Lewis (1985) in an effort to address these variables. The questionnaire consists of twenty-four questions most of which are multiple choice or scale responses and thus quantitative in nature.

3.4.3.Personal Information Questionnaire

The personal information questionnaire was constructed to measure the independent variables to be investigated in the study. As specified in section 3.1, the most important independent variables are:

- Profession (Psychologist, Psychiatrist, Pentecostal minister or Mainstream minister)
- Religious Affiliation
- Self professed degree of religious belief
- Religious orientation, consisting of the 21 item Religious Orientation Scale (ROS)
- Use of religion in practice

In addition to these major variables, several other variables were identified as potential confounding variables:

- Theoretical therapeutic position with which the practitioner identifies
- Length of time working in your profession
- Age
- Gender

The questionnaire was confidential, but if the respondents wanted information relating to the study, they were requested to include their details with the completed questionnaire. The questions in this questionnaire assessing respondents' profession, length of time working in that profession, age, gender and degree of self professed religiousness are taken from Liebenberg (1992). The question on religious affiliation is taken from Shafranske and Maloney (1990), while the question on therapists' theoretical position was designed for this questionnaire by the researcher.

The Religious Orientation Scale (ROS) as proposed by Allport and Ross (1967) was shown in the literature review to be a widely used and tested method of measuring religious belief. Many authors reviewed in this thesis have advocated the use of the ROS, particularly when using the fourfold typology (Bergin, 1991; Bergin et al., 1987; Bergin et al., 1988; Donahue, 1985; Richards and Bergin, 1997; Wulff, 1991). The ROS was used in preference to Batson and Ventis's Religious Life Inventory (RLI) (Donahue, 1985) since the ROS has been more widely used and the RLI may suffer from a lack of construct validity and other problems, as discussed in section 2.2.3. Questions 8 to 27 are items from the ROS and were taken from Wulff (1991, p.230). The final six questions in the questionnaire (questions 28-33) investigate the use of religion in practice and were taken from Shafranske and Maloney (1990, pg. 75).

3.5. Procedure

A pilot study as suggested by Gartner et al. (1990) was carried out. This consisted of the case study, questionnaire on the case study and the personal questionnaire being administered to three clinical psychology interns at the Midlands hospital complex and three ministers of religion from Durban. These subjects were chosen because of ease of access and because they would not be part of the later, final group.

These subjects completed the questionnaires and offered feedback to the researcher on possible improvements that could be made to the questionnaire. The intern psychologist respondents felt that the case study was well presented, but the ministers suggested that it was couched in too much psychological language. To counteract this for the main study, language that is more neutral was used in the case study. The ministers also criticised the use of the word "religion". They suggested that "spirituality" would be a more effective term. In response to this suggestion, the covering letter that was sent out to ministers of religion (Appendix E), was modified to request that they understand the term religion to refer to spirituality as well as the more formal aspects of religion. The pilot study suggested that the questionnaire and case study were reliable for use with psychologists and ministers as the three intern psychologists offered similar responses to one another, as did the three ministers. All three of the intern psychologists diagnosed the client as having a psychotic disorder.

The main study used the hypothetical case study as modified after the pilot study, the questionnaire on the hypothetical case study and the personal questionnaire. All potential subjects as identified in the lists from section 3.3 were contacted telephonically to ask whether they would be willing to participate in the study. Where subjects could not be contacted on the first attempt, messages were left and two more attempts were made to contact each subject. From the potential subjects that were contacted, a list of participants in the study was obtained. Those who consented to participate in the study were sent a copy of the introductory letter (Appendix D and E), case study (Appendix A), questionnaire on the case study (Appendix B) and the personal questionnaire (Appendix C), together with a self-addressed, stamped envelope. As illustrated in The research instruments

were then sent out to those who agreed to participate by post, accompanied by a self addressed, stamped envelope and a covering letter, requesting them to return the completed questionnaires to the researcher.

Three weeks after the questionnaires had been sent, all respondents were contacted telephonically again, to request that they return the completed questionnaires as soon as possible. The responses from the completed questionnaires were then captured into an SPSS version 10.0 database (SPSS, 1998) and coded to facilitate statistical analysis. The data-file was then carefully checked to ensure that the data had been correctly entered. Thereafter, the statistical analyses as outlined below were conducted.

3.6. Statistical Analysis

Statistical analysis was conducted by using SPSS version 10.0 (SPSS, 1998). Descriptive tests and cross-tabulations were run initially to give a descriptive overview of the data. Since most of the items being analysed are ordinal or nominal variables, and therefore do not represent normal distributions, it was necessary to use non-parametric tests for the main data analysis. Ordinal data were therefore analysed by means of conducting Mann-Whitney U-tests where the groups contained two independent groups and the Kruskal Wallis H-test where three or more independent groups were being analysed. Where the data being analysed were nominal, Chi-squared tests were conducted. The results of this data analysis are presented below.

4. RESULTS

An initial presentation of the descriptive statistics for the respondents appears below, followed by a discussion of the findings in relation to the two main hypotheses (which were subdivided into six sub-hypotheses in section 3.2).

4.1. Descriptive Statistics

4.1.1. General Descriptive Statistics

Table 2 shows the respondents' sex by their profession. As can be seen from the table two thirds of the total number of respondents were male. However, there were noticeable differences between mental health professionals and ministers of religion in terms of their gender. Most of the mainstream and Pentecostal ministers were male, while slightly more than half of both psychiatrist and psychologist respondents were female. This discrepancy does however appear to follow the general patterns for these professions, as most ministers of religion are male, while the field of mental health has a more equal male female distribution in South Africa.

Table 2: Sex by Profession

	Pentecostal Minister		Mainstream Minister		Psychologist		Psychiatrist		Total	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Female	1	7.7%	2	11.1%	10	58.8%	5	55.6%	18	31.6%
Male	12	92.3%	16	88.9%	7	41.2%	4	44.4%	39	68.4%
Total	13	100.0%	18	100.0%	17	100.0%	9	100.0%	57	100.0%

The range of ages by profession is shown in table 3. The table shows cumulative percentages of the ages. Most of the respondents appeared to be aged between thirty and forty-nine years of age, with less than one in ten respondents being under thirty. In general, mainstream ministers tended to be older than the other respondents,

while Pentecostal ministers were generally younger than other respondents. However, since Pentecostal ministers and mainstream ministers are considered together for the data analysis, their age profiles is fairly similar to that of the mental health professionals.

Table 3: Age by Profession

	Pentecostal Minister		Mainstream Minister		Psychologist		Psychiatrist		Total	
	No.	Cum Percent	No.	Cum Percent	No.	Cum Percent	No.	Cum Percent	No.	Cum Percent
20-29	2	15.4%	2	11.1%	1	5.9%	0	0.0%	5	8.8%
30-39	8	76.9%	2	22.2%	4	29.4%	3	33.3%	17	38.6%
40-49	1	84.6%	5	50.0%	9	82.4%	6	100.0%	21	75.4%
50 and above	2	100.0%	9	100.0%	3	100.0%	0	100.0%	14	100.0%
Total	13		18		17		9		57	

Table 4 shows the length of time that the respondent has been qualified. In retrospect, this question may have been more useful had it been phrased to reflect the number of years the respondents had been working in their identified profession, as several respondents reported that they had no formal qualification. However, the data as it stands at present indicates that half of the respondents had been qualified for between six and twenty years. Only four ministers and two psychologists had been qualified longer than this. One-third of the Mainstream ministers and one-quarter of the Pentecostal ministers indicated that they had not received any formal training. The psychiatrist group reported somewhat less experience than most of the other groups with almost half of having been qualified for less than two years.

Table 4: Length qualified by profession

	Pentecostal Minister		Mainstream Minister		Psychologist		Psychiatrist		Total	
	No.	Cum Percent	No.	Cum Percent	No.	Cum Percent	No.	Cum Percent	No.	Cum Percent
0-2 years	0	0.0%	0	0.0%	1	5.9%	4	44.4%	5	9.3%
3-5 years	4	30.8%	2	13.3%	2	17.6%	1	55.6%	9	25.9%
6-10 years	2	46.2%	3	33.3%	6	52.9%	2	77.8%	13	50.0%
11-20 years	4	76.9%	1	40.0%	6	88.2%	2	100.0%	13	74.1%
>21 years	0	76.9%	4	66.7%	2	100.0%	0	100.0%	6	85.2%
Unqualified	3	100.0%	5	100.0%	0	100.0%	0	100.0%	8	100.0%
Total	13		15		17		9		54	

4.1.2.Religious beliefs of the respondents.

Section 2.3.3 discusses the different religious orientations when using a fourfold typology based on respondents' answers to the items on the ROS. Donahue (1985, p.401) describes them as follows:

- Those who agreed with items on the Intrinsic (*I*) scale and disagreed with items on the Extrinsic (*E*) scale he called *intrinsics.*
- Those who disagreed with items on the *I* scale and agreed with items on the *E* scale he called *extrinsics.*
- Those who agreed with items on both scales he called *indiscriminately proreligious* (or *indiscriminate*).
- Those who disagreed with items on both scales he called *indiscriminately antireligious* (or *non-religious*).

As one may expect from the sample all of the Pentecostal ministers and all but one of the Mainstream ministers who completed the Religious Orientation Scale were found to be intrinsically religious. The other mainstream minister was indiscriminately pro-religious. As can be seen from table 5, the pattern for psychologists and psychiatrists was markedly different. Just over fifty percent of the psychologist group who completed the Religious Orientation Scale was intrinsically religious, while only two were indiscriminately pro-religious. The remaining 35 percent were non-religious. Forty-five percent of the psychiatrist group was non-religious, while 22

percent was intrinsically religious. The remaining third was indiscriminately pro religious. Most interestingly, none of the respondents was extrinsically religious.

Table 5: Religious Orientation of the respondents

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist
Intrinsic	12	16	9	2
Extrinsic	0	0	0	0
Indiscriminate	0	1	2	3
Non-Religious	0	0	6	4
Refused to Answer	1	0	2	0

As anticipated, all of the ministers reported that they were Christians, but belonging to different denominations. Table 6 shows that over 80% of the psychologists surveyed reported some religious affiliation. Seventy percent reported that they were Christian, while 12% reported that they were Buddhist and the remaining 18% reported that they held no religious affiliation. Nearly 90% of the psychiatrists surveyed claimed some affiliation with religion. Fifty five percent reported that they were Christian, 11% reported that they had no religious affiliation, while the remaining 30% was equally divided between Islam, Hindu and other religions.

Table 6: Religious Affiliation of the respondents

	Christian	Other	None
Pentecostal Ministers	13	0	0
Mainstream Ministers	18	0	0
Psychologists	11	2	3
Psychiatrists	5	3	1

Table 7 reflects the church attendance for the respondents and indicates that all of the ministers attend services at least once a week as expected. However, nearly 50% of psychologists and nearly 90% of psychiatrists rarely attend services. Overall, 62% of the mental health practitioners attend services rarely if at all.

Table 7: Frequency of attending religious meetings

	At least once a week	2-3 times per month	Rarely
Pentecostal Minister	13	0	0
Mainstream Minister	17	0	0
Psychologist	2	7	8
Psychiatrist	1	0	8

4.2. Mental Health Professionals vs. Ministers

Significant differences were found in many of the analysed items between mental health professionals and ministers of religion. These will be discussed in detail below, with reference to the particular hypothesis associated with them. The questions addressing the particular hypothesis are identified in the tables below. The questionnaire number will be shown for each item and an explanation of the items will also be given.

4.2.1.Nature of the problem

For the analysis of this data, the respondents who felt that the client did not have a problem (as specified in question 1) were excluded from the analysis as there were only two respondents who held this belief and they therefore caused the Chi squared test to show cells with expected frequencies below 5. Excluding these cases facilitated better analysis of the data, although it must be noted that one cell (shown in italics in table 8) had an expected value of 4.36, therefore suggesting that the results should be interpreted with a degree of caution. Analysis of the data shows a very significant difference ($p < 0.001$, from table 8a) between mental health

practitioners and ministers of religion in their assessment of whether the client's problem is religious, psychiatric or a combination of religious and psychiatric in nature (Question 1 in the questionnaire (See appendix B). As can be seen from table 8, none of the ministers identified the problem as exclusively psychiatric in nature, while 10 of the Mental Health Professionals did. Similarly only one of the Mental Health Professionals identified the problem as being exclusively religious in orientation while 13 of the ministers felt that it was. The remainder of the respondents from both groups identified the problem as both psychiatric and religious in nature.

Table 8: Chi Squared table of Type of Profession by assessment of the problem (Q1).

		Ministers	Mental Health Professionals	Total
Religious issue	Observed	13	1	14
	Expected	7.89	6.11	14
Psychiatric problem	Observed	0	10	10
	Expected	5.64	4.36	10
Combined psychiatric and religious problem	Observed	18	13	31
	Expected	17.47	13.53	31
Total	Observed	31	24	55
	Expected	31	24	55

Table 8a: Significance levels

Chi-Square Tests	Value	Degrees of Freedom	Significance
Pearson Chi-Square	20.53	2	0.001***
Cramer's V	0.61		0.001***
Number of Valid Cases	55		

Table 8b shows a more detailed breakdown between the four different types of respondents, namely Pentecostal ministers, mainstream ministers, psychologists and psychiatrists. From this breakdown, one can see that most of the Pentecostal ministers identified the problem as a religious issue, while most of the mainstream ministers

identified the problem as a combined religious and psychiatric problem. Most of the psychologists also identified the problem as a combined psychiatric and religious problem, while two thirds of the psychiatrists identified the problem as purely psychiatric. This suggests that the greatest difference in opinions exists between Pentecostal ministers and psychiatrists while the mainstream ministers and psychologists expressed similar views on the nature of the problem.

Since the differences between ministers and mental health professionals were significant, Hypothesis 1a is accepted.

Table 8b: Table of Profession by Problem

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
No problem	0	0	2	0	2
Religious issue	10	3	1	0	14
Psychiatric problem	0	0	4	6	10
Combined psychiatric and religious	3	15	10	3	31
Total	13	18	17	9	57

4.2.2. The most beneficial person for the client

Question 24 in the questionnaire addresses the issue of who is the most beneficial person for a religious client. To facilitate analysis of the data recorded in this question, the responses were re-coded into three groups (psychiatrist, psychologist and minister). The findings are shown in table 9. The results in table 9a show a very high significance level ($p < 0.001$) for differences between mental health professionals and ministers of religion. The table shows a strong tendency for ministers to identify a minister of religion as the most beneficial person for the client, while the mental health professionals were far more likely to believe that a psychiatrist was the most beneficial person for the client. Although both ministers of religion and mental health professionals identified

psychologists as the most beneficial person for the client, mental health professionals were more likely to identify this group.

Table 9: Chi squared table of Type of profession by their opinions of the most therapeutic person for the client.

		Ministers	Mental Health Professionals	Total
Psychiatrist	Observed	3	14	17
	Expected	9.25	7.75	17
Psychologist	Observed	6	11	17
	Expected	9.25	7.75	17
Minister	Observed	22	1	23
	Expected	12.51	10.49	23
Total	Observed	31	26	57
	Expected	31	26	57

Table 9a: Significance Levels

Chi-Square Tests	Value	Degrees of Freedom	Significance
Pearson Chi-Square	27.54	2	0.001***
Cramer's V	0.70		0.001***
Number of Valid Cases	57		

Although the small group sizes did not allow a chi-squared analysis of the data in table 9b, it still offers a useful analysis of this variable. The table shows that almost all the Pentecostal ministers and all the psychiatrists identified a member of their own profession as the most beneficial for the client. However, psychologists and mainstream ministers, although they were more inclined to identify their own professions as the most beneficial person, also identified other professions as beneficial for the client. Therefore, it again appears that most of the significant difference can be explained by the difference between psychiatrists and Pentecostal ministers.

Table 9b: Table of Profession by "Most beneficial Profession"

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Psychiatrist	0	3	5	9	17
Psychologist	1	5	11	0	17
Minister	12	10	1	0	23
Total	13	18	17	9	57

Table 10 gives the results of a Mann Whitney U test between Ministers and Mental Health Professionals on the six options offered in question 24, which respondents were asked to rank from most beneficial to the client (1) to least beneficial (6). Only the category "minister with counselling skills" ($p<0.001$) and "psychiatrist regardless of beliefs" proved to be significant. Table 10a shows that most of the ministers felt that a minister with good counselling skills would be best for the client. By contrast, the mental health professionals did not overwhelmingly select a particular category meaning the other results were non-significant and tables of this data can be found in tables 47 to 51 in appendix F.

Consequently, one can accept hypothesis 1b, which asserts that ministers of religion and mental health professionals will differ in their opinions of who is the most beneficial person for a religious client.

Table 10: Mann-Whitney U tests of Type of Profession by Most Therapeutic person for the client.

Item	Mann Whitney U	Z	Significance level (p)
Psychiatrist regardless of beliefs	274.0	-2.245	0.025*
Psychiatrist with same beliefs	347.5	-0.913	0.361
Psychologist regardless of beliefs	308.5	-1.562	0.118
Psychologist with same beliefs	396.5	-0.107	0.915
Minister with same beliefs	303.0	-1.913	0.056
Minister with counselling skills	153.5	-4.129	0.001***

Table 10a: Table of Type of profession by "Minister with counselling skills" as therapeutic person.

Rankings	Ministers	Mental Health Professionals	Total
1	19	1	20
2	4	6	10
3	3	4	7
4	0	2	2
5	1	4	5
6	4	9	13
Total	31	26	57

4.2.3. The most beneficial mode of treatment for the client

Several questions address differences between mental health practitioners and ministers of religion in their assessment of the most beneficial mode of treatment for religious clients. The first of these is an assessment of the most beneficial type of treatment for the client, as posed by question 8 in the questionnaire. This question again asked respondents to rank different types of treatment from most beneficial (1) to least beneficial (9). A chi squared analysis of this question, recoding the responses into categories of Religious treatment or Psychological/ Psychiatric treatment for the respondents' first choice of treatment, produces the results shown in table 11 below. As can be seen from the table, there was a very significant difference ($p<0.001$) between the two groups in their assessment of what type of treatment would be most beneficial for the client. Ministers identified religious treatment as the most beneficial form of intervention, while the mental health professionals identified psychological or psychiatric interventions as more beneficial.

Table 11: Chi squared table of Type of Profession by most beneficial treatment for the client (Q8).

		Ministers	Mental Health Professionals	Total
Religious Treatment	Observed	24	2	26
	Expected	14.18	11.82	26
Psychological or Psychiatric Treatment	Observed	6	23	29
	Expected	15.82	13.18	29
Total	Observed	30	25	55
	Expected	30	25	55

Table 11a: Significance levels

Chi-Square Tests	Value	Degrees of Freedom	Significance
Pearson Chi-Square	28.36	1	0.001***
Cramer's V	0.72		0.001***
Number of Valid Cases	55		

Table 11b allows an analysis of the categories by the four different types of professions. As can be seen from the table all the Pentecostal ministers stated that religious treatment was their first choice of treatment for the client, while all the psychiatrists stated that psychiatric treatment was their first choice of treatment for the client. Again mainstream ministers and psychologists tended to choose their own profession as their first choice of treatment, but were more flexible in this. Thus, the strongest differences for this variable are between Pentecostal ministers and psychiatrists.

Table 11b: Table of Profession by First treatment

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
No treatment	0	1	1	0	2
Psychiatric treatment	0	4	1	9	18
Psychotherapy	0	2	7	0	9
Religious Treatment	13	11	2	0	19
Total	13	18	17	9	57

An individual analysis of these items in question eight using a Mann Whitney U test confirms these findings. As can be seen from table 12, all the options showed very significant findings except for the option of no treatment. Individual tables illustrating these results can be found in tables 31 to 38 in appendix F. Table 31 in Appendix F illustrates that a range of ranks was given to the option of "No Treatment" by both ministers of religion and mental health professionals. However, the mental health professionals gave much more importance (lower ranks) to the options of "Psychiatric Treatment", "Medication", "Hospitalisation", and "Psychotherapy", while the ministers of religion gave more importance to "Pastoral counselling", "Spiritual Healing" and "Prayer and Intercession". Very few responses were given for the category "other" and consequently this has not been analysed.. More detailed analysis of these variables is shown in tables 39 to 46 also in appendix F. Table 39 illustrates that, although there was not a significant relationship for "No Treatment", there did appear to be minor differences in the priority scores given to this variable by different professions. All psychiatrists gave this variable a ranking of six or below, while two fifths of the Pentecostal ministers gave it a ranking of five or better. Although this was not significantly better, it is interesting to note. Tables 40 to 46 show that the major differences again appear to be between Pentecostal ministers and psychiatrists over all the variables but particularly for religious and psychiatric treatment types, while the mainstream ministers and psychologists often give similar rankings to variables.

Table 12: Mann-Whitney U test of Type of Profession by assessment of the most beneficial mode of treatment.

Item	Mann Whitney U	Z	Significance level (p)
No Treatment	310.5	-1.53	0.13
Psychiatric Treatment	206	-3.19	0.001***
Medication	196	-3.35	0.001***
Hospitalization	232	-2.77	0.01**
Psychotherapy	211.5	-3.10	0.01**
Pastoral Counselling	93	-5.10	0.001***
Spiritual Healing	211	-3.10	0.01**
Prayer and Intercession	174.5	-3.70	0.001***

Two other measures from the questionnaire give information about differences between mental health professionals and ministers of religion in their assessment of the most beneficial mode of treatment for the client. The first of these is an assessment of whether the client needs to be hospitalised, while the second assesses the client's need for medication. Although ministers of religion are not experts in either of these fields, it offers important assessments of the perceived level of severity of the client's problems. Table 13 shows the results of a Mann Whitney U test, which was conducted using these variables. As can be seen from the table both variables again show a very strong level of significance ($p<0.001$). Tables 13a and 13b show the direction of this difference. It is clear from these tables that the mental health professionals perceive hospitalisation and medication to be far more essential or useful than ministers of religion, most of whom felt that this measure would be either unnecessary or harmful to the client.

Table 13: Mann-Whitney U test of Type of Profession by assessment of need for hospitalisation or medication.

Item	Mann Whitney U	Z	Significance level (p)
Need for Hospitalisation (Q18)	185.5	-3.458	0.001***
Need for Medication (Q19)	153.5	-3.605	0.001***

Table 13a: Table of Type of Profession by Need for Hospitalisation.

	Ministers	Mental Health Professionals	Total
Would be essential	0	4	4
Would be helpful	2	10	12
Would make little difference	7	3	10
Would be unnecessary	8	5	13
Would be undesirable	13	4	17
Total	30	26	56

Table 13b: Table of Type of Profession by Need for Medication.

	Ministers	Mental Health Professionals	Total
Would be essential	1	11	12
Would be helpful	9	8	17
Would make little difference	3	2	5
Would be unnecessary	7	2	9
Would be undesirable	8	2	10
Total	28	25	53

Tables 13c and 13d again show the breakdown for the assessment of the need for medication and hospitalisation by profession. The same trend as found previously is illustrated in this data, where the Pentecostal ministers and psychiatrists show the most extreme differences with the psychologists and mainstream ministers having similar views. It can be seen from the table that most of the psychiatrists felt that it would be either helpful or essential

for the client to be both medicated and hospitalised, while most of the Pentecostal ministers felt this would be either unnecessary or undesirable. Therefore, since all of these measures are highly significant hypothesis 1c is accepted.

Table 13c: Table of Profession by Need for Hospitalisation

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Would be essential	0	0	1	3	4
Would be helpful	0	2	4	6	12
Would make little difference	1	6	3	0	10
Would be unnecessary	4	4	5	0	13
Would be undesirable	7	6	4	0	17
Total	12	18	17	9	56

Table 13d: Table of Profession by Need for Medication

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Would be essential	0	1	3	8	12
Would be helpful	3	6	7	1	17
Would make little difference	1	2	2	0	5
Would be unnecessary	3	4	2	0	9
Would be undesirable	4	4	2	0	10
Total	11	17	16	9	53

4.2.4. Assessment of the client's levels of impairment

Three variables from the questionnaire assess the client's level of impairment. These are the respondent's assessment of the client's degree of disturbance, level of stress and level of maturity (Q5, 6 and 7 respectively). These variables were analysed by means of a Mann-Whitney U test and the results are shown in table 14. The

table illustrates a highly significant difference in their assessment of the client's degree of disturbance (Q5, $p < 0.001$) and a significant difference in their assessment of the degree of stress the client is under (Q6, $p < 0.05$). Table 14a illustrates that the mental health professionals identified the client's level of disturbance as more severe than the ministers did. However, table 14b shows that the ministers perceived the client to be under significantly more stress than their mental health counterparts, which is contrary to the expectations of the researcher. There was no significant difference between the two groups in their perceptions of the client's level of maturity (Q7). Table 14c suggests that this may be attributed to both groups identifying the client as having a moderate level of maturity.

Table 14: Mann-Whitney U Test of Type of Profession by assessment of client's levels of impairment.

Item	Mann Whitney U	Z	Significance level (p)
Degree of Disturbance (Q5)	208	-3.257	0.001***
Degree of Stress (Q6)	267	-2.154	0.03*
Degree of Maturity (Q7)	307	-1.582	0.11

Table 14a: Table of Type of Profession by Level of Disturbance.

	Ministers	Mental Health Professionals	Total
Severely Disturbed	0	6	6
Moderately Disturbed	14	15	29
Mildly Disturbed	10	4	14
Not disturbed at all	6	1	7
Total	30	26	56

Table 14b: Table of Type of Profession by Level of Stress.

	Ministers	Mental Health Professionals	Total
Severe Stress	9	2	11
Moderate Stress	13	12	25
Mild Stress	7	9	16
No Stress	1	3	4
Total	30	26	56

Table 14c: Table of Type of Profession by Level of Maturity.

	Ministers	Mental Health Professionals	Total
Very Immature	12	6	18
Moderately Immature	17	17	34
Moderately Mature	1	3	4
Total	30	26	56

Tables 14d to 14f show these variables broken down across the four professions. Table 14d illustrates that the mainstream ministers and psychologists gave exactly the same ratings to the client's level of disturbance. This therefore implies that the significant difference is to be found between Pentecostal ministers and psychiatrists. The table indicates that all the psychiatrists considered the client to be severely or moderately disturbed, while the majority of the Pentecostal ministers reported that the was only mildly disturbed or not disturbed at all. Table 14e confirms the finding above that there is no significant relationship between the different groups of respondents in their assessment of the degree of stress that the client is experiencing. Finally, table 14f shows that the psychologists and mainstream ministers again had identical responses to the question on the client's level of maturity, while the Pentecostal ministers felt that the client was less mature than the psychiatrists.

The contrasting results make it difficult to accept or reject hypothesis 1d. However, since the variable "Degree of Disturbance" appears to most comprehensively address the issue of the client's level of impairment, it would seem that hypothesis 1d may be correct. However, this evidence may not be strong enough to accept it.

Table 14d: Table of Profession by Degree of Disturbance.

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Severely Disturbed	0	0	0	6	6
Moderately Disturbed	2	12	12	3	29
Mildly Disturbed	6	4	4	0	14
Not disturbed at all	5	1	1	0	7
Total	13	17	17	9	56

Table 14e: Table of Profession by Degree of Stress.

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Severe Stress	3	6	2	0	11
Moderate Stress	4	9	8	4	25
Mild Stress	5	2	5	4	16
No Stress	1	0	2	1	4
Total	13	17	17	9	56

Table 14f: Table of Profession by Level of Maturity.

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Very Immature	7	5	5	1	18
Moderately Immature	6	11	11	6	34
Moderately Mature	0	1	1	2	4
Total	13	17	17	9	56

4.2.5.Assessment of the important factors in healing

Table 15 shows the analysis of four variables using a Mann-Whitney U test to assess the differences between mental health professionals and ministers of religion in their assessment of the important factors in healing the client. All four of these variables showed a very significant difference ($p < 0.01$). The first of these four measures from the questionnaire was how responsive the respondents felt the client would be to them if they were to treat him (Responsiveness to treatment - question 11). Table 15a illustrates that Ministers were much more likely to believe that the client would make significant improvements in any intervention that they might implement with the client than the mental health group were. The second question was how motivated the respondents felt the client was to any treatment plan (Motivation - question 15). Table 15b shows that the minister group also perceived the client as having higher motivation in any of their interventions, while table 15c shows that the ministers suggest that the client had more insight into his difficulties than did the mental health group (measured by question 16). Finally, table 15d shows that the mental health group felt that it was much more unlikely that the client would make good progress with them in any intervention than the minister group did (question 17).

Table 15: Mann-Whitney U test of Type of Profession by important healing variables with a client.

Item	Mann Whitney U	Z	Significance level (p)
Responsiveness to treatment (Q11)	128	-4.564	0.001***
Motivation to treatment (Q15)	234	-2.720	0.007**
Insight into behaviour (Q16)	232	-2.871	0.004**
Expected progress (Q17)	228.5	-2.641	0.008**

Table 15a: Table of Type of Profession by Responsiveness to intervention.

	Ministers	Mental Health Professionals	Total
Very Responsive	4	0	4
Moderately Responsive	20	5	25
Minimally Responsive	4	10	14
Rather Unresponsive	2	8	10
Very Unresponsive	0	3	3
Total	30	26	56

Table 15b: Table of Type of Profession by Motivation to intervention.

	Ministers	Mental Health Professionals	Total
Highly motivated	1	0	1
Moderately motivated	8	1	9
Low motivation	16	16	32
Completely unmotivated	4	9	13
Total	29	26	55

Table 15c: Table of Type of Profession by Level of Insight.

	Ministers	Mental Health Professionals	Total
Moderate	5	1	6
Low	21	14	35
No Insight	3	11	14
Total	29	26	55

Table 15d: Table of Type of Profession by Anticipated Progress.

	Ministers	Mental Health Professionals	Total
Very likely	5	1	6
Moderately likely	22	15	37
Fairly unlikely	2	7	9
Not at all	0	1	1
Total	29	24	53

Although Kruskal Wallis tests were not conducted across the finer four group level, since the aim of this section is to compare mental health professionals to ministers of religion, tables 15e to 15h offer interesting insights into the above results. Table 15e shows that a breakdown of the expected responsiveness of the client by profession suggests that the Pentecostal and mainstream ministers both view the client as moderately to very responsive, while the psychologists and psychiatrists view the client as likely to be less responsive. A breakdown of the client's motivation to treatment shows similar response patterns by psychologists and mainstream ministers, while the psychiatrists tended to view him as less motivated, while the Pentecostal ministers reported that he would be more motivated, as shown in table 15f. The significant difference between mental health professionals and ministers of religion in their assessment of the client's level of insight appears to be explained by the differences in opinion of psychiatrists and Pentecostal Ministers. The Pentecostal ministers report in table 15g that the client has low to moderate insight whilst all but one of the psychiatrists reported that they he had no insight. Finally, table 15h illustrates that the significant difference in the projected levels of progress with the client appear to be explained by a difference in opinions between psychologists and both minister groups, with particular reference to the Pentecostal ministers.

Since all four measures in this section were found significant, hypothesis 1e can also be accepted.

Table 15e: Table of Profession by Responsiveness to intervention.

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Very Responsive	4	0	0	0	4
Moderately Responsive	7	13	4	1	25
Minimally Responsive	1	3	7	3	14
Rather Unresponsive	1	1	4	4	10
Very Unresponsive	0	0	2	1	3
Total	13	17	17	9	56

Table 15f: Table of Profession by Motivation to intervention.

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Highly motivated	0	1	0	0	1
Moderately motivated	5	3	1	0	9
Low motivation	5	11	11	5	32
Completely unmotivated	2	2	5	4	13
Total	12	17	17	9	55

Table 15g: Table of Profession by Level of Insight.

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Moderate	4	1	1	0	6
Low	7	14	13	1	35
No Insight	1	2	3	8	14
Total	12	17	17	9	55

Table 15h: Table of Profession by Expected Progress.

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Very likely	4	1	0	1	6
Moderately likely	8	14	8	7	37
Fairly unlikely	0	2	6	1	9
Not at all	0	0	1	0	1
Total	12	17	15	9	53

4.2.6.Assessment of the role played by religious beliefs in any problems

Three questions addressed the role of the client's beliefs. These were whether the client needed to change his beliefs to improve (question 22), the role his beliefs played in any difficulties he may be experiencing (question 21) and finally, how the respondent would deal with the client's religious beliefs (question 23).

A Mann-Whitney U test exhibited a very significant difference ($p < 0.01$) between mental health practitioners and ministers with regards whether the client needed to change his religious beliefs to improve (table 16). However, table 16a shows that the direction of this difference was not as hypothesised, with all but one of the ministers believing it would be either essential or useful for the client to change his religious beliefs.

Table 16: Mann Whitney U Test of Type of Profession by in their assessment of the role of beliefs in any difficulties experienced by a client.

Item	Mann Whitney U	Z	Significance level (p)
Need to change beliefs (Q22)	211	-3.014	0.003**

Table 16a: Type of Profession by Need to change Beliefs.

	Ministers	Mental Health Professionals	Total
Would be essential	19	7	26
Would be helpful	10	10	20
Would make little difference	0	4	4
Would be unnecessary	0	3	3
Would be undesirable	1	1	2
Total	30	25	55

Table 16b indicates that the surprise finding of a significant difference between mental health professionals and ministers of religion in assessing whether the client needs to change his beliefs may be attributable to the psychologist group. They were more likely than the other three respondent groups to feel that is was undesirable, unnecessary or would make little difference for the client change his beliefs.

Table 16b: Table of Profession by Need to change Beliefs

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Would be essential	10	9	0	7	26
Would be helpful	3	7	8	2	20
Would make little difference	0	0	4	0	4
Would be unnecessary	0	0	3	0	3
Would be undesirable	0	1	1	0	2
Total	13	17	16	9	55

Table 17 shows the results of a chi-squared analysis of the second variable that investigates the role played by religious beliefs in the client's life. This variable is found in question 21 on the questionnaire, which asks the respondents what role they feel the client's beliefs play. Table 17a illustrates indicates a significant difference ($p<0.05$) between ministers of religion and mental health professionals in their assessments of the role played by beliefs in any difficulties the client is experiencing. As can be seen from table 17, the mental health professionals

were significantly more likely to suggest that the client's beliefs were a result of his pathology, while the ministers expressed the view that his beliefs were either normal or a causative factor in his difficulties.

Table 17: Chi-squared table of Type of Profession by Role of Beliefs (Q21).

		Ministers	Mental Health Professionals	Total
Beliefs are a causative factor in any difficulties	Observed	12	4	16
	Expected	8.9	7.1	16
Beliefs are result of his difficulties	Observed	9	17	26
	Expected	14.4	11.6	26
Beliefs are normal/unrelated to any difficulties	Observed	10	4	14
	Expected	7.8	6.3	14
Total	Observed	31	25	56
	Expected	31	25	56

Table 17a: Significance tests

Chi-Square Tests	Value	Degrees of Freedom	Significance
Pearson Chi-Square	8.49	2	0.014*
Cramer's V	0.389		0.014*
Number of Valid Cases	56		

Table 17b shows that the psychologist and psychiatrist group had similar opinions of the role of the client's beliefs in his difficulties. However, the Pentecostal minister group was far more likely than the mainstream minister group to feel that the client's beliefs were causing his difficulties. The mainstream ministers were more likely than the other groups to feel that the client's beliefs are normal for his group or unrelated to any difficulties.

Table 17b: Table of Profession by Role of Beliefs

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Beliefs are a causative factor in any difficulties	9	3	3	1	16
Beliefs are result of his difficulties	2	7	9	8	26
Beliefs are normal/unrelated to any difficulties	2	8	4	0	14
Total	13	18	16	9	56

The final question investigating the role of the client's religious beliefs is question 23, which asks the respondents how they would deal with the client's religious beliefs. Table 18a shows that a chi-squared analysis of this question reveals an extremely significant difference ($p<0.001$) between mental health professionals and ministers of religion on this question. Table 18 shows that most of the ministers responded that they would discuss the client's religious beliefs with him or try to get him to change his beliefs, whereas mental health professionals were more inclined merely to listen to the beliefs and not act upon them.

Table 18: Chi-squared table of Type of Profession by Dealing with Beliefs.

		Minister	Mental Health Profession	Total
Discuss his religious beliefs with him	Observed	23	12	35
	Expected	19.0	16.0	35
Try to get him to change his religious beliefs	Observed	8	3	11
	Expected	6.0	5.0	11
Listen to, but not discuss, his religious beliefs	Observed	0	11	11
	Expected	6.0	5.0	11
Total	Observed	31	26	57
	Expected	31	26	57

Table 18a: Significance tests

Chi-Square Tests	Value	Degrees of Freedom	Significance
Pearson Chi-Square	16.42	2	0.001***
Cramer's V	0.537		0.001***
Number of Valid Cases	57		

The final table in this section looks at a more detailed breakdown of how the different groups would deal with the client's beliefs. Both the Pentecostal and mainstream ministers were most likely to discuss the client's beliefs with him, while the remainder of these respondents stated that they would try to change his beliefs. Over half of the psychologists stated that they would discuss his beliefs with him, but only a third of the psychiatrists stated that they would do the same. Over half of the psychiatrists would only listen to the client's beliefs, while one third of the psychologists stated that this was how they would deal with his beliefs.

All three of the measures from this section show significant differences between mental health professionals and ministers of religion and therefore, hypothesis 1f is accepted.

Table 18b: Table of Profession by Dealing with Beliefs

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
Discuss his beliefs with him	10	13	9	3	35
Try to change his beliefs	3	5	2	1	11
Listen to, but not discuss his beliefs	0	0	6	5	11
Total	13	18	17	9	57

4.3. Mental Health Professionals with different Religious Orientations and religious beliefs

Due to the small sample size of psychologists and psychiatrists, it was not possible to conduct analyses of any power on the data, for differences between mental health professionals with different religious orientations. Those analyses that were conducted showed very little support for the proposed hypotheses. Most of the items examined showed no differences between the intrinsically, extrinsically and indiscriminately religious mental health practitioners. It is important to note that none of the mental health professionals was found to be extrinsically religious and only five were found to be indiscriminately religious, while the others were fairly evenly spread between non religious and intrinsically religious. The specific hypotheses are discussed below.

4.3.1.Nature of the problem

Due to the small sample size, it was not possible to conduct a chi-squared analysis of the two questions which investigate the nature of the client's problem. These are question 1, the nature of the client's problem, and question 2, the diagnosis ascribed to the client. Table 19 indicates that there is a reasonably equitable distribution of attributions for the problem across the three types of religious orientation. However, it does appear that intrinsically religious respondents were more likely to give some attribution for the client's problems to religious considerations, as almost two-thirds described the problem as a combined religious and psychiatric issue. In contrast, the non-religious and indiscriminately religious respondents were more likely to describe the client's problem as psychiatric in nature.

The second question to investigate the nature of the problem was the client's diagnosis. Table 20 shows that almost all the respondents who gave a diagnosis, regardless of their religious orientation, gave a diagnosis of either psychotic process or schizophrenia. Table 20a looks at whether there were any differences in diagnosis between psychiatrists and psychologists. Although there were no apparent differences between mental health

professionals of different religious oreintations, it is clear that the psychiatrists were unanimous in their diagnosis of the client as schizophrenic, while the psychologists offered diagnoses that are more varied.

Since there is no evidence of a significant difference between mental health professionals of different religious orientations in their assessment of the nature of the client's problem, hypothesis 2a is not accepted.

Table 19: Religious Orientations of Mental Health Professionals by assessment of the nature of the client's problem.

	Intrinsic	Indiscriminate	Non-religious	Total
No problem	1	0	1	2
Religious issue	0	0	1	1
Psychiatric problem	3	2	5	10
Combined psychiatric and religious problem	7	3	3	13
Total	11	5	10	26

Table 20: Religious Orientations of Mental Health Professionals by Axis 1 Diagnosis given to client.

	Intrinsic	Indiscriminate	Non-religious	Total
Delusional Disorder	0	0	1	1
Schizophrenia/ Schizoaffective Disorder	6	4	7	17
Obsessive Compulsive Disorder	0	1	0	1
Psychotic Process	3	0	0	3
Schizotypal Personality Disorder	1	0	0	1
Total	10	5	8	23

Table 20a: Table of Profession by Diagnosis Axis1

	Psychologist	Psychiatrist	Total
Delusional Disorder	1	0	1
Schizophrenia/ Schizoaffective Disorder	6	9	17
Obsessive Compulsive Disorder	1	0	1
Psychotic Process	3	0	3
Schizotypal Personality Disorder	1	0	1
Total	14	9	25

4.3.2.The most beneficial person for the client

Table 21 presents the respondent's first choice of the most therapeutic person for the client as asked in question 24, where respondents were asked to rank the options from most therapeutic (1) to least therapeutic (6). Although there were insufficient numbers to conduct a chi-squared test, one can see from the table that there was very little difference between the intrinsically religious, indiscriminately religious and non-religious mental health professionals in their assessments of what type of professional would be the most beneficial for the client. However, there did appear to be a tendency for indiscriminately religious respondents to recommend psychiatric treatment.

Table 21: Religious Orientations of mental health professionals by first choice of "Most Therapeutic Person" (Question 24).

	Intrinsic	Indiscriminate	Non-religious	Total
Psychiatrist	4	4	6	14
Psychologist	6	1	4	11
Minister	1	0	0	1
Total	11	5	10	26

An analysis of each of the options offered in question 24, using their rankings, was also conducted using a Kruskal Wallis H test. These results are presented in table 22. The options of "psychologist regardless of their beliefs" and "psychologist with the same beliefs" were found to be significant ($p<0.01$ and $p<0.05$ respectively). Table 22a suggests that non-religious mental health professionals were more likely to believe a psychologist regardless of their beliefs would be therapeutic for the client, while the intrinsically religious respondents gave this option a very low ranking, with almost half suggesting that this would be the least therapeutic option for the client. By contrast, the intrinsically religious respondents reported their belief that a psychologist who shares the client's beliefs would be the most therapeutic person for the client, while both indiscriminately religious and non-religious respondents felt this would be less beneficial for the client. A tabular presentation of the non-significant findings can be seen in tables 52 to 55 in appendix F.

Hypothesis 2b, which states that there will be significant differences between mental health professionals of different religious orientations, does not appear to be adequately supported by this data. Although there is some evidence of a difference in their views of the role to be played by psychologists, this does not appear to be sufficient to accept the hypothesis. Consequently, hypothesis 2b is not accepted, but note is taken of the different roles assigned to psychologists who share the same beliefs as the client and those who do not.

Table 22: Kruskal Wallis H Test of Religious Orientations of mental health professionals by "Most therapeutic person" (Q24).

Variable	Chi-Squared	Degrees of Freedom	Significance level (p)
Psychiatrist regardless of beliefs	3.38	2	0.18
Psychiatrist with same beliefs	0.68	2	0.71
Psychologist regardless of beliefs	8.92	2	0.01**
Psychologist with same beliefs	6.35	2	0.04*
Minister with same beliefs	0.29	2	0.87
Minister with counselling skills	3.39	2	0.18

Table 22a: "Psychologist Regardless of beliefs" as most therapeutic person by ROS for mental health professionals.

Ranking	Intrinsic	Indiscriminate	Non-religious	Total
1	0	0	3	3
2	1	2	2	5
3	0	0	1	1
4	3	0	3	6
5	1	1	1	3
6	6	2	0	8
Total	11	5	10	26

Table 22b: "Psychologist with same beliefs" as most therapeutic person by ROS for mental health professionals.

Ranking	Intrinsic	Indiscriminate	Non-religious	Total
1	6	1	1	8
2	3	0	2	5
3	0	0	2	2
4	0	0	3	3
5	0	0	1	1
6	2	4	1	7
Total	11	5	10	26

4.3.3.The most beneficial mode of treatment for the client

Several measures were used to assess the respondents' perceptions of the most beneficial mode of treatment for the client. The first of these was investigated in question 8 where the respondents were asked to rank several possible forms of "treatment" for the client from most beneficial (1) to least beneficial (9). Table 23 shows a table of the respondents' first choice of treatment by groups of intrinsically religious respondents, indiscriminately religious respondents and non-religious respondents. Again, the sample size was too small to conduct a chi-

squared test. The table shows an even distribution for intrinsic and non-religious respondents, although the indiscriminately religious respondents were more likely to recommend psychiatric treatment for the client.

Table 23: First type of Treatment Selected (Question 8) by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
No Treatment	0	0	1	1
Psychiatric Treatment	6	4	6	16
Psychological Treatment	4	0	3	7
Religious Treatment	1	1	0	2
Total	11	5	10	26

A Kruskal Wallis H test was conducted on each individual option for question 8 to assess whether there were any significant differences between mental health professionals of different religious orientations on any specific type of treatment. As shown in table 24 only prayer and intercession proved to be significant ($p<0.05$). Table 24a indicates that this may be due to the intrinsically religious respondent ranking prayer and intercession as moderately important, whilst non-religious, and particularly indiscriminately religious respondents, ranked it as unimportant. Tables of the results that were found non-significant can be seen in tables 56 to 62 in Appendix F. Very few responses were given for the category "other" and consequently this category is not shown in the analysis.

Table 24: Kruskal Wallis H Test of Religious Orientations of mental health professionals by "Most beneficial treatment" (Q8).

Variable	Chi-Square	Degrees of Freedom	Significance level (p)
No Treatment	2.79	2	0.25
Psychiatric Treatment	0.85	2	0.65
Medication	0.75	2	0.69
Hospitalization	3.94	2	0.14
Psychotherapy	2.08	2	0.35
Pastoral Counselling	3.84	2	0.15
Spiritual Healing	0.58	2	0.75
Prayer and Intercession	7.12	2	0.03*

Table 24a: Prayer and Intercession by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	0	0	0	0
2	0	0	0	0
3	2	0	0	2
4	1	0	1	2
5	2	0	1	3
6	4	1	3	8
7	1	0	2	3
8	0	1	0	1
9	1	3	3	7
Total	11	5	10	26

The final measure from the questionnaire of the most beneficial form of treatment for the client is reflected in the questions asking respondents how important they believed hospitalisation and medication were for the client (questions 18 and 19 respectively). Table 25 shows that a significant difference existed between mental health professionals of different religious orientations for their assessment of whether the client would benefit from hospitalization ($p < 0.05$), but not in whether he would benefit from medication. Table 25a shows that the

intrinsically religious respondents felt that hospitalisation would be less beneficial than did the indiscriminately religious and non-religious respondents.

Therefore, the evidence tends to suggest that, although there were some areas of significant difference, notably in the assessment by mental health professionals of different religious orientation of the client 's need to be hospitalised and for the benefit of prayer and intercession, that there is not enough evidence to support hypothesis 2c. Therefore, this hypothesis is not accepted.

Table 25: Kruskal Wallis H Test of Religious Orientations of mental health professionals by need for hospitalisation and medication.

Variable	Chi-Square	Degrees of Freedom	Significance level (p)
Need Hospitalisation? (Q18)	6.97	2	0.03*
Need Medication? (Q19)	3.60	2	0.16

Table 25a: Need Hospitalization by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Would be essential	0	3	1	4
Would be helpful	4	1	5	10
Would make little difference	1	1	1	3
Would be unnecessary	3	0	2	5
Would be undesirable	3	0	1	4
Total	11	5	10	26

Table 25b: Need Medication by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Would be essential	2	4	5	11
Would be helpful	6	0	2	8
Would make little difference	1	1	0	2
Would be unnecessary	1	0	1	2
Would be undesirable	1	0	1	2
Total	11	5	9	25

4.3.4.Assessment of the client's levels of impairment

Three questions from the questionnaire addressed the question of the client's level of impairment. These were the client's degree of disturbance, his level of maturity and the degree of stress that he is under (questions 5, 6 and 7). Table 26 shows that a Kruskal Wallis H test of these variables reveals no significant differences between mental health professionals of different religious orientations. These results can be seen in more detail in tables 63 to 65 in appendix F. Therefore, hypothesis 2d is also not accepted.

Table 26: Kruskal Wallis H Test of Religious Orientations of mental health professionals by assessment of the client's levels of impairment.

Variable	Chi-Square	Degrees of Freedom	Significance Level (p)
Degree of Disturbance (Q5)	0.91	2	0.63
Degree of Maturity (Q6)	0.27	2	0.87
Degree of Stress (Q7)	0.06	2	0.97

4.3.5.Assessment of the important factors in healing

There was also no difference between mental health professionals of different religious orientations in their perceptions of the important variables in healing religious clients with psychological difficulties. This was analysed by conducting Kruskal Wallis H tests on the four relevant variables: responsiveness to treatment (question 11); motivation to treatment (question 15); insight into behaviour (question 16); and expected progress (question 17) (shown in table 27). All of these variables showed no significant differences and detailed tables of the relationship can be seen in table 66 to 69 in appendix F. Consequently, hypothesis 2e is not accepted.

Table 27: Kruskal Wallis H Test of Religious Orientations of mental health professionals by assessment of the important healing variables with a client.

Variable	Chi-Square	Degrees of Freedom	Significance level (p)
Responsiveness to treatment (Q11)	0.21	2	0.90
Motivation to treatment (Q15)	2.82	2	0.24
Insight into behaviour (Q16)	4.04	2	0.13
Expected progress (Q17)	0.41	2	0.81

4.3.6.Assessment of the role played by religious beliefs in any problems

Three questions from the survey investigate the role played by religious beliefs in the client's difficulties. The first of these is question 22 where the respondent is asked whether the client needs to change his beliefs to improve. Table 28 shows the results of a Kruskal Wallis H test of the data and indicates that there is no significant difference between mental health professionals of different religious orientations in their assessment of this variable. A detailed table of the relationship can be seen in appendix f, table 70.

Table 28: Differences between Mental Health Practitioners of different Religious Orientations in their assessment of the role of beliefs in any difficulties experienced by a client.

Variable	Chi-Square	Degrees of Freedom	Significance level (p)
Need to change beliefs (Q22)	1.35	2	0.51

Table 29 shows the mental health professionals' responses to question 21, the role of the client's religious beliefs in any difficulties he is experiencing by the different religious orientations of the respondents. Although it was not possible to conduct a chi-squared analysis of the data, the table shows an even distribution of responses across the categories.

Table 29: Role of Beliefs by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Beliefs are an important causative factor in pathology	0	0	1	1
Beliefs are a minor causative factor in pathology	1	1	1	3
Beliefs are result of psychiatric difficulties	7	4	6	17
Beliefs are normal for group to which he belongs	2	0	2	4
Total	10	5	10	25

Finally, table 29a shows the responses of mental health professionals divided into their religious orientations in response to question 23 which asks the respondents how they would deal with the client's religious beliefs. Again, even though it was not possible to conduct a chi-squared test with this data, table 29a indicates that the responses are equally distributed across the different religious orientations.

Therefore, hypothesis 2f does not appear to be supported by the current data and is therefore rejected.

Table 29a: Dealing with Beliefs by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Suggest he discuss religious beliefs with someone else	0	1	0	1
Discuss his religious beliefs with him	6	1	6	13
Listen to his religious beliefs but not discuss them	4	2	2	8
Try to get his religious beliefs to a more stable point	1	1	0	2
Let him direct whether to discuss his religious beliefs	0	0	1	1
Listen to his religious beliefs as a metaphor	0	0	1	1
Total	11	5	10	26

4.4. Summary

The results of this study indicate that Mental Health Professionals and Ministers of religion have significantly different understandings of a religious clients difficulties or problems and the manner in which one should treat these difficulties. These differences include their assessment of the nature of the client's problem and the role played by religious beliefs in any problems, his level of impairment, the most beneficial mode of treatment and the most beneficial person for the client as well as their understanding of the important factors in healing. The differences are most evident between psychiatrists and Pentecostal ministers. By contrast, there do not appear to be any significant differences between mental health professionals of different religious orientations as defined by Allport and Ross(1967).

5. DISCUSSION OF RESULTS

5.1. Introduction

The results reported in the previous chapter will be discussed in more detail in this chapter. The discussion will begin with a review of the descriptive statistics and the religious affiliation and commitment of the respondents to shed light on the following results. The data analysis has investigated the differences between mental health professionals and ministers of religion in their assessment of the important variables of the case study. It has also analysed the differences between mental health professionals of different religious orientations and their assessments of the case study. These will be addressed below as separate issues.

5.2. Descriptive statistics

Differences were evident in the sex distribution of mental health professionals and ministers of religion. Although this may appear to be a confounding variable in the study, it must be noted that the respondents' sexes are likely to be representative of the sex distribution of their respective professions. Ministers of religion are predominately male whereas psychologists and psychiatrists have a more equal male to female ratio. Therefore, sex should not be considered a confounding variable in the analysis as the sex distribution of the respondents represents a "normal" sex distribution for their professions.

As noted in the previous section, although Pentecostal ministers tended to be younger than the other respondents and mainstream ministers tended to be older, these groups were combined for the data analysis and therefore showed a similar age distribution to the mental health professionals. It is important to note that two out of seven ministers reported having no formal training to be a minister. There is, however, no indication of how long they have been working as a minister of religion, which may mitigate against their lack of formal qualifications. It is also important to note the psychiatrist group was less experienced than the other groups, in terms of number of years of training. Almost half of this group had been qualified for less than two years and this

may affect their assessments of the case. However, this did not appear to be the case as the psychiatrists appeared to offer the most uniform responses to the questionnaire.

The findings of the religious orientations of mental health professionals were similar to results obtained by Bergin and Jensen (1990), who surveyed 425 mental health professionals and found that a little under 25% were intrinsically religious, another 25% were indiscriminately pro religion, 5% were extrinsic and the remaining half were non-religious or refused to answer. Therefore, this study's findings appear to confirm their findings. By contrast, Bergin et al. (1987) found 98.6% of a sample consisting of 119 college psychology students and 32 theology students to be Intrinsically religious. The significant difference in religious orientations between mental health professionals and ministers of religion is not unexpected, but may further explain some of the significant differences between these two groups.

Similarly, the findings on religious affiliation are consistent with the findings by Bergin and Jensen's (1990) findings that 80% of therapists have some religious affiliation and suggests that religion may be an important factor for South African mental health practitioners. Since the client in the case study is a Christian, it is important to note that 45% of the psychiatrists and 30% of the psychologists reported that they were non-Christians. Shafransky and Maloney (1990) felt that religious affiliation was not as good an indication of true religious belief as church attendance. The high levels of non attendance by mental health professionals, and in particular psychiatrists, suggests a low level of religious commitment amongst these respondents and may further emphasise differences in opinion between them and the ministers of religion, all of whom stated that they attend services regularly.

5.3. Differences between Mental Health Professionals and Ministers in their assessment of the case study

Differences were analysed between the mental health professionals and ministers to address the hypotheses outlined in section 3.2. Further analysis was conducted to investigate the differences between psychologists, psychiatrists, Pentecostal and mainstream ministers. These results shed further light on the discussion, but should be interpreted with a degree of caution as the sample sizes, particularly for psychiatrists were small.

5.3.1. Assessment of the nature of the problem

An extremely significant difference ($p<0.001$) was found between mental health professionals and ministers of religion in their assessments of the nature of the client's problem. Although this is not entirely unexpected, it is very important information. This study appears to indicate that psychologists and mainstream ministers have similar views on the religious client in the case study, while the major difference exists between psychiatrists and Pentecostal ministers. The case study in this research was intentionally set up to represent a Pentecostal Christian client and therefore, the benchmark for culturally appropriate religious behaviour is given by the Pentecostal ministers. Consequently, this suggests that there may be a degree of bias displayed by psychiatrists, psychologists and mainstream ministers towards the client, although this bias is most evident from the psychiatrists in the study.

Houts and Graham (1986), Lewis and Lewis (1985) and Wadsworth and Cheketts (1980) reported a lack of bias by mental health professionals, which may contrast with the current finding of significant differences between mental health professionals and ministers of religion. The finding may however be in line with a body of research conducted by Bergin (1983), Dishington (1996), Littlewood and Lipsedge (1997), Sevensky (1984) and Tillman (1998), which argues that the mental health profession does display some bias in their assessments of religious clients.

Gartner et al. (1990) have argued that measures focussing exclusively on diagnosis are not an adequate measure of bias amongst mental health professionals. Consequently, it is important to explore any other differences between ministers and mental health professionals on the other variables in the case study.

5.3.2.The most therapeutic person

The analysis of who the Mental Health Professionals and the ministers consider to be the most beneficial person to treat the client in the case study indicates a very high significance level ($p. < .001$). All the ministers identified a minister of religion as the most beneficial person for the client, while the mental health professionals felt that either a psychologist or psychiatrist was more beneficial for the client. Again, these findings are not unexpected but they do contribute to the overall understanding of this case. One possible explanation of this finding is that the two groups have little knowledge or understanding of the benefits of the other group's interventions. However, the finding may also represent an element of bias from the mental health professionals against the religious client.

The ministers, and in particular the Pentecostal ministers, represent people of authority from the culture of the client in the case study and thus portray the opinions that this culture has formed of individuals with similar characteristics to those represented in the case study. The major differences were again found to exist between Pentecostal ministers and psychiatrists, both of whom were likely to identify their own profession as the most beneficial for the client. The fact that all but one of the Pentecostal ministers felt that a minister would be the best person to help the client suggests that they feel the client's problems are within their sphere of expertise. None of these ministers identified a psychiatrist as the most beneficial person for the client, while all the psychiatrists felt they would be the most beneficial for the client. The psychologists also displayed a resistance to having the client treated by a minister, with only one identifying this as the most beneficial treatment. Therefore, it appears

that there is resistance amongst mental health professionals to allowing religious clients to be treated by ministers of religion as well as resistance from ministers of religion to allowing these clients to be treated by members of the mental health profession.

The findings from this section also show that a high proportion of ministers identified the most therapeutic person for the client as a "minister with counselling skills". This suggests that, although most of the ministers in the sample place a high level of importance on psychological awareness and counselling skills, they feel that it is important for religious clients to be treated by ministers of religion. However, it must be noted that this may not necessarily indicate a conflict of values so much as a potential "turf war".

5.3.3.Most beneficial mode of treatment

A very significant difference was found between mental health practitioners and ministers of religion in their assessment of the most beneficial mode of treatment for religious clients. All of the psychiatrists surveyed suggested that the most beneficial form of treatment for the client would be to see a psychiatrist. In contrast, all but one of the Pentecostal ministers felt that a minister would be the most therapeutic person for the client. Although the mainstream ministers and the psychologists were more diverse in their opinions they also tended to recommend their own profession as the most therapeutic for the client. This is consistent with the findings mentioned above. Although this appears to illustrate a natural bias to recommend one's own profession, it also suggests that mental health practitioners give little consideration to ministers as a beneficial healer for their religious clients.

A very significant difference was also found between mental health professionals and ministers in their opinions of whether the client should be hospitalised or placed on medication. Again, all of the psychiatrists felt that it would be important for the client to be hospitalised, while all but one of the Pentecostal ministers felt this would

be either unnecessary or undesirable. The majority of mainstream ministers and psychologists also felt that it would be unnecessary or undesirable for the client to be hospitalised. Similarly, all of the psychiatrists felt that the client should be medicated, while the majority of ministers felt it would be unnecessary or undesirable. The psychologists were largely undecided. This huge discrepancy between the psychiatrists and the ministers, in particular the Pentecostal ministers, again raises the question of bias in the psychiatrist group. It is important to note however, that most of the psychiatrists in the sample work in a hospital setting, thus inclining them to be more in favour of hospitalisation. It may therefore be unreasonable to generalise this finding to all psychiatrists in private practice as well.

5.3.4.Degree of impairment and disturbance

There was no significant difference between the two groups on their perception of the client's level of maturity, but there was a significant difference in their assessment of his degree of stress and degree of disturbance. Mental health professionals identified the client's level of disturbance as significantly more severe than the ministers did ($p. < .001$). Again, the major differences appeared to exist between psychiatrists and Pentecostal ministers, although both psychologists and mainstream ministers were also likely to see the client as more disturbed than their Pentecostal counterparts did. This is consistent with the findings of Abramowitz and Dokeci (1977) who concluded that client values (and therefore the client's religious beliefs) were a major predictor of therapist bias. This also supports Gartner et al's (1990) finding that clients with extreme religious views (as in this case where the client is a Pentecostal Christian) were rated more severely by clinicians than more moderately religious or non-religious clients.

Contrary to expectations, the ministers perceived the client to be under significantly more stress than their mental health counterparts ($p. < .05$). Although the researcher can find little in the literature to explain this finding, it may perhaps be explained by the nature of the clients seen by the different professions. It is likely that psychologists

and psychiatrists see clients under more stress than that represented by the client in the case study on a regular basis, while ministers will on average see clients under less stress. Therefore, these rankings may merely represent a comparison to the cases they experience on a daily basis. Another possible explanation for this unexpected finding is that the word "stress" may contain less negative connotations than the word "disturbance", and the ministers of religion may therefore be willing to ascribe some of the client's difficulties to stress instead of disturbance.

5.3.5.Healing variables

There was a very significant difference between mental health practitioners and ministers of religion in their perceptions of the important variables in healing religious clients with psychological difficulties. Four measures from the questionnaire were addressed at assessing this and all four measures were significant. Ministers were much more likely to believe that the client would make significant improvements in any intervention that they might implement than the mental health group. The minister group also perceived the client as having higher levels of motivation in any of their interventions and suggested that he had more insight into his difficulties than did the mental health group. It is interesting to note that the psychiatrist group appeared to account for the differences in assessing the client's level of insight, with most stating that the client had no insight. The other three groups all rated his insight as low. Finally, the mental health group felt that it was much more unlikely that the client would make good progress with them in any intervention than the minister group did. Here it appeared that the psychologists were less likely to feel the client would make progress in treatment with them, perhaps suggesting that they were not confident of psychological treatment's ability to solve this religious client's problems.

It is possible that the mental health professionals' perceptions of the client as having low motivation, low insight, poor prognosis and poor chance of improving in an intervention with them may reflect a clash of world views. By

contrast, the ministers may feel that the client has a better rating on these scales because they have a world view which is closer to that of the client. Therefore this section may again suggest a potential bias against religious clients by mental health professionals, and suggests that these clients are perceived as less open to treatment and less likely to succeed in any treatment with the client. It is possible that this is reflective of mental health professionals inability to be value neutral towards their clients (Bergin, 1980a, 1991; Coyne, 1976; Littlewood and Lipsedge, 1997; McLemore and Court, 1977; Richards and Bergin, 1997; Sevensky, 1984; Tillman, 1998; Worthington, 1988) and may reflect a natural bias against those with very different world views to oneself (Gartner et al., 1990; Houts and Graham, 1986).

5.3.6.Role of beliefs

A very significant difference was evidenced in the opinions of mental health practitioners and ministers with regards whether the client needed to change his religious beliefs to improve. However, the direction of this difference was unexpected with all but one of the ministers believing it would be either essential or useful for the client to change his religious beliefs. The psychologists were the only respondents who felt it would not be necessary for the client to change his beliefs in order to improve. This is a confusing finding, particularly since psychological theories, particularly cognitive behavioural theories, would appear to argue that it is important for client's to change their beliefs in any form of therapy in order to improve. However, the explanation may lie in the psychologists' apparent unwillingness to talk to the client about his religious beliefs as evidenced in question 23, where many of the psychologists reported that they would listen to his beliefs but not discuss them. This may represent an unwillingness to become engaged with the client in areas that the psychologists feel they are not trained or knowledgeable in.

There was also a significant difference between mental health professionals and ministers of religion in their assessment of what role the client's beliefs played in any difficulties he was experiencing. The ministers were

more likely to feel that his beliefs caused his behaviour, while the mental health professionals reported that his beliefs were the result of his psychological difficulties. This seems to represent a different understanding of religious behaviour between the two groups. It appears that many of the mental health professionals, particularly the psychiatrists believe that religious beliefs can be attributed to psychiatric disorder. This was a view put forward by Ellis (1980) and many theorists before him, which has largely been discredited in recent years, as discussed in the literature review. However, this analysis of this question suggests that some of the mental health professionals from this sample may attribute the client's behaviour and religious beliefs to and underlying psychiatric problem.

Finally, there was a very significant difference in the way the two groups would deal with the client's beliefs, with most of the ministers suggesting that they would discuss them with him, whereas mental health professionals were more inclined merely to listen to the beliefs and not act upon them. As discussed above, this may have impacted on the psychologist's perception that the client does not need to change his religious beliefs in order to improve. However, this may represent appropriate behaviour on behalf of the mental health professionals as the ethical code suggests they should not act outside their area of expertise and knowledge.

5.4. Differences between intrinsically, extrinsically and indiscriminately pro religious Mental Health Professionals.

It was hypothesised that there would be differences between the mental health professionals with an intrinsic religious orientation and those with an indiscriminate or extrinsic religious orientation across several different variables. Most of these were found non-significant. As noted earlier, the literature indicates that individuals with an intrinsic religious orientation and those with a non-religious orientation often have similar scores on measures of prejudice. In this case, 81% of the mental health respondents who completed the Religious Orientation scale were either intrinsic or non-religious, while the remainder was indiscriminately pro-religious. The lack of significance in the data analysis may be partly explained by this skewed data set. Another complicating factor for

the analyses in this section was the small sample size, which, together with the skewed data on religious orientation meant that it was not possible to conduct chi-squared tests on the nominal data in this section.

Although no chi-squared test was conducted due to the small sample size a perusal of the data suggests that it is unlikely that a significant difference would have been found between mental health professionals of different religious orientations in their assessment of the nature of the client's problem. There was an increased tendency for intrinsically religious respondents to suggest that there was a religious component to the problem, but this was only moderately higher than for other religious orientations. Several theorists (Houts and Graham, 1986; Lewis and Lewis, 1985; Wadsworth and Checketts, 1980) have argued that therapists do not display bias based on their own beliefs when assessing their clients. These findings appear to add to this body of literature by suggesting that mental health practitioners in South Africa do not appear to display bias based on their religious orientation.

One of the two variables displaying a significant difference between the different religious orientations was the assessment of whether a psychologist would be the most beneficial person to treat the client ($p. < 0.05$). However, this may be attributed to the higher number of intrinsically religious psychologists than psychiatrists in the group, thus reflecting a difference between psychologists and psychiatrists as opposed to mental health practitioners of different religious orientations. The other significant variable was whether the client need to be hospitalised ($p. < 0.05$). The indiscriminately pro religious group and the non-religious group tended to be more in favour of hospitalising the client. However, this may again represent a difference between psychologists and psychiatrists as the latter were far more likely to fall into the indiscriminately pro religious or non-religious groups and were more likely to be working in a hospital setting.

In an attempt to investigate whether these findings for the Religious Orientation Scale are consistent, several other analyses were run. The Religious Orientation Scale was re-coded as suggested by Bergin et al. (1987) to

reflect the true median as opposed to the hypothetical median of the sample. Donahue (1985) and Wulf (1991) have argued that failing to use the standardised medians provides a less valid analysis, as it decreases the power of comparison across studies. The results of the revised religious orientation of mental health professionals using the true medians are reflected in table 30. The medians were 29 for the intrinsic scale (hypothetical median: 27) and 26 for the extrinsic scale (hypothetical median: 33). Using these true medians increased the number of extrinsic respondents in the sample. However, analysis of the data using the true medians did not show any significant differences across any of the variables (see Appendix G for a full list of the variables analysed and their significance levels).

Table 30: Religious Orientation of the respondents re-coded to reflect the true median (according to Bergin et al., 1987).

	Psychologist	Psychiatrist
Intrinsic	6	0
Extrinsic	1	4
Indiscriminate	5	3
Non-Religious	5	2
Refused to Answer	2	0

5.5. Conclusions

The results from the first half of this research indicate that there are very significant differences between mental health professionals and ministers of religion when considering a religious client. The most marked differences are between psychiatrists and Pentecostal ministers. These differences may represent an area of potential bias based on the client's religious affiliation, in line with that noted in the literature by Bergin (1991), Gartner et al. (1990), Houts and Graham (1986), Shafranske and Maloney (1990), and Worthington (1988). This would have important implications for South African psychology and psychiatry where "Pentecostal" religious clients such as

the client represented in the case study may be hospitalised against the recommendations of the religious community.

This finding suggests that mental health professionals need to strive to increase their awareness of what is considered culturally appropriate by the client's culture, including his or her religious culture, as advocated by the DSM IV (APA, 1994). It is also important for subsequent versions of the DSM to stress the importance of considering the client's culture more explicitly, in an attempt to encourage psychologists and psychiatrists to be more aware of their own cultural bias. Jones (1994) has discussed the need for a closer working relationship between religion and psychology predicated upon mutual trust and respect. The findings here also emphasise the need for a closer working relationship between the theological and mental health fraternities. This gap could be addressed by an increased awareness of religion and its positive and negative consequences in the clinical training programmes for psychology and psychiatry (Lewis and Lewis, 1985; and Richards and Bergin, 1997). Further research into religion and the clinical practice of psychology and psychiatry that is published in popular psychological and psychiatric journals, would further promote a more neutral and accepting approach towards religion.

Some authors have become advocates for the positive role of religion in mental health such as Bergin (1980a, 1980b, 1983, 1991) and Richards and Bergin (1997). However, although they advocate the use of religion in therapy, this is not necessarily implied by the current research. This thesis suggests only that mental health practitioners need to acknowledge their potential bias against religious clients and that they need to be willing to consult religious authorities from the client's community before diagnosing him or her with a disorder. Sturdier, replicable research will contribute to an increased acceptance of religion, as a valid concept within the field of mental health.

The results from the second half of this study also have some valid implications for the literature. The first implication is that a degree of caution may be required when using the religious orientation scale in modern day South Africa. The scale may have a propensity to produce too many false positive intrinsic and indiscriminate results.

Another implication of this research is that mental health professionals do not appear to differ in their assessment of religious clients based on their own religious differences. This is contrary to the assertions of theorists such as Bergin (1983), Dishington (1996), Sevensky (1984) and Tillman (1998) that non-religious therapists will be more prejudiced against their religious clients than religious therapists. However, the findings in this study appear to indicate that mental health professionals may tend to be biased against religious clients, irrespective of their own personal religious beliefs. This would appear to be a facet of their training and the underlying antagonism of psychology towards religion (Bergin, 1980a; Lewis and Lewis, 1985).

Thus, although this research does not support the hypothesis that non-religious therapists will be more biased towards their religious clients, it does support the theory put forward by Bergin (1991), Houts and Graham, (1986), Jones, 1994, and Larson et al. (1986), that psychologists have different conceptions of religion than the religious public.

It is not in the scope of this thesis to argue whether religion may represent a form of psychopathology or whether religion represents a true path of belief that the mental health profession appears to undermine. It is however the goal of this thesis to comment on the application of the current Diagnostic and Statistical Manual (DSM IV, APA, 1994) being used by mental health practitioners. As mentioned in section 2.3.5, the DSM IV motivates for clinicians to consider the "cultural appropriateness" of their clients' beliefs and behaviours before diagnosing them. The Pentecostal ministers were included in this study to provide a standard of cultural appropriateness for Pentecostal Christian individuals, such as that represented by the client in the case study. It is therefore

significant that so many differences appear to exist between Pentecostal Ministers and Mental Health Professionals. This difference appears to be further exaggerated when one looks at the differences between psychiatrists and Pentecostal ministers.

It is therefore important for the fields of psychology and psychiatry to re-evaluate their stance towards religious clients in general, and Pentecostal Christian clients specifically. The multicultural movement has revolutionised the way traditional cultures are viewed from a psychiatric perspective (Draguns, 1990; and d'Ardenne and Mahanti, 1989), with spirit healers being considered to be outside the domains of a psychotic diagnosis. Perhaps it is time that this acceptance of culturally appropriate behaviour be extended also to "Western" religious beliefs.

6. STRENGTHS AND LIMITATIONS OF THE STUDY

6.1. Generalisation of results

This study has attempted to cover as wide a range of subjects as possible to facilitate a wider generalisation of the results. Thus, this study may be generalised to both psychologists and psychiatrists. However, the topic dealt exclusively with bias towards a **Christian** religious client, and these results therefore refer only to bias against a Christian client. Due to the nature of psychiatry and psychology in South Africa, the race composition of the subjects was predominately White with a few Asian respondents. No black subjects were involved in the study. Any bias towards the client represented in this study can therefore only be said to come from White or Asian psychologists and psychiatrists. It would be a useful exercise to conduct this study with a group of African mental health practitioners and to have a case study representing a different religion.

6.2. Limitations of the Instruments

The Religious Orientation Scale (ROS) is recognised as one of the best measures of religion in the literature (Wulff, 1991; Donahue, 1985. However, the ROS has faced several criticisms. Donahue (1985) notes that the ROS is effective when administered to Christian subjects, but may be less efficient when the subjects are non-Christian. In this study, several of the respondents identified themselves as non-Christians and the scale may therefore have been ineffective. The concept of extrinsic religion has also received criticism from the literature (ibid.) The finding that so many of the respondents were intrinsically religious while none of them was extrinsically religious may further cast doubt on the validity of the extrinsic scale of the ROS. Batson and Ventis's (1982) Q scale may have been useful in this study as it purports to measure religion outside of the concept of Christianity, which would have been applicable to many of the mental health workers in this study.

A further word of caution needs to be raised about the validity of the hypothetical case study and the corresponding questionnaire. Although the case study was based on others found in the literature, the researcher has deliberately made some of the client's religious characteristics ambiguous. Although this may represent a realistic case, it is the first time this case study has been used in conjunction with the questionnaire and there are no statistics on reliability and validity of these measures.

However, the hypothetical case study and the questionnaire represent strengths of the study as well. They are derived from an extensive body of literature as outlined in section 3.4. The ambiguity evident in the case study is representative of the usual ambiguity facing any psychologist or psychiatrist when formulating a case. This ambiguity should further elicit the biases of the respondents as they will interpret the information in the way which best suits their understanding of religious clients.

6.3. Composition of Sample and Analysis of Findings

The sample was constructed from lists of psychologists, psychiatrists and ministers of religion in the Midlands area of KwaZulu Natal. It is however likely that these lists were not inclusive of all the possible respondents in the area. This may therefore represent a bias in the sampling. Further, the low response rates amongst psychiatrists and Pentecostal Christian ministers may represent a response bias in these groups, as only those who felt most strongly about mental health and religion may have responded.

Due to the lower than anticipated response rates, the total number of subjects in the psychiatrist and Pentecostal Minister groups was low. Thus, the statistics do not have an ideal level of power. However, as combined groups of mental health practitioners and ministers of religion the group sizes were significantly better at 28 and 30 respectively. This may suggest a need for the results of the study to be interpreted with a degree of caution.

7. CONCLUSIONS

This study sought to investigate the differences between mental health workers and ministers of religion in their impressions of a religious client to assess whether mental health practitioners display a bias against religious clients. The study found very significant differences between mental health professionals and ministers of religion in their assessments of that religious client. The most obvious differences were between psychiatrists and Pentecostal ministers. These differences represent an area of potential bias in mental health professionals, based on the client's religious affiliation.

The implications for South African psychology and psychiatry are that mental health professionals may need to review their values when dealing with religious clients, particularly "Pentecostal" Christian clients. It also suggests that psychologists and psychiatrists have not been willing to apply the clause specified by DSM IV (APA, 1994) that therapists should consider whether the client's behaviours are culturally appropriate. This may represent either an honest error of diagnosis or a conscious bias against religious clients.

To avoid the former error occurring it is important that mental health professionals' attention is drawn to the need for considering the client's cultural background, particularly their religious backgrounds. This may be done in a number of ways. There is a need for a closer working relationship between psychologists and ministers of religion when dealing with religious clients (Jones, 1994). A closer working relationship between the two professions will be more likely to foster a respect of each other's beliefs and disciplines. Increasing the emphasis given to religion and mental health in clinical training programmes for psychology and psychiatry will also foster an increased respect and tolerance towards religion amongst mental health practitioners (Lewis and Lewis, 1985; and Richards and Bergin, 1997). Finally, increased research into religion and mental health being published in popular mental health journals would facilitate a better understanding of the role religion plays in mental health.

The second aim of this study was to investigate whether the mental health practitioners' religious beliefs impact on assessments of religious clients. The study appears to confirm the findings of Houts and Graham (1986), Lewis and Lewis (1985) and Wadsworth and Checketts (1980) that mental health professionals do not display bias on the basis of their own religious beliefs. This appears to refute the assertions of theorists such as Bergin (1983), Dishington (1996), Sevensky (1984) and Tillman (1998) that non-religious therapists will be more prejudiced against their clients than religious therapists.

However, the findings of this study indicate that all mental health professionals, irrespective of their own religious affiliations judge the mental health of their religious clients more harshly than the client's community leaders believe they should be judged. It is therefore essential in South Africa, where prejudice on the basis of race, gender, or religion is so strongly condemned by the constitution, that psychologists and psychiatrists show an increased awareness of their own prejudices against religious clients.

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9. APPENDIX A: CASE STUDY OF JOHN

John is a 28 year old man who was referred to the psychiatric clinic by his father, after his father had grown increasingly concerned for his well being over the past year. He is not married and reports few relationships in his past. Those relationships that he does describe typically lasted no more than one month. John finished school when he was aged 18 and, at his parent's insistence registered for a B.Comm at his local university. He completed the degree in four years, after having to repeat one year for failing a subject. After completion of his degree, John was approached by a colleague and offered a job as a bookmaker in the local TAB where he worked for five years.

When John was 25 a friend introduced him to the local church. He believed this was a "life changing experience" and says he was converted to Christianity within a month. He became increasingly involved in the church's activities, attending two church services on a Sunday and was involved in other activities such as bible studies, drama groups, worship meetings, etc. every night of the week. Consequently, John saw less and less of his friends as he claimed that all they did was drink together and God had told him to give up drinking. His parents began to express concern to John when he told them that he was not able to see them as often as before since God had told him to be more involved in the church, and consequently his parents felt that John's involvement in religion was unhealthy. However, over the past two years, he became increasingly involved in the church and reports speaking in tongues, having been given visions of heaven from God during church services and private prayer times, and hearing God speak to him. An example of the visions that John reports experiencing is as follows: "While I was praying in church last week I saw a crowd of people – all of whom I know, mostly friends from church - living in peace with one another and gathering around a crystal throne where they all kneel to worship the lamb sitting on the throne, while the seraphim fly around us singing hymns of praise".

John stated that he quit his job at the TAB seven months prior to the referral after being increasingly convicted by God that his profession was wrong and reports that "God told me he would supply all my needs". Since this time John has not tried to find work, claiming that God will provide, but has done routine maintenance at the church without remuneration and is currently staying with a member of the congregation. His father also stated that he had become further concerned when John told him that he had given away many of his clothes to people on the street because God had told him to do so. When John was asked about this, he responded that "if God can look after the birds of the air and the lilies of the field, can he not look after me all the better".

In the initial consultation, John presented as tall and thin, dressed somewhat untidily and he reported not having had time to wash during the morning because his daily devotion had finished late. In the interview he appeared calm, and seemed to exhibit socially appropriate behaviour, although he became somewhat defensive when his father indicated that he was "mentally ill". He seemed to speak normally although his emotions did not always appear consistent with the topic about which he was talking and he was occasionally a bit vague during the interview. He reported that he was not experiencing any psychological difficulties, and claimed that he was only living the life that God had instructed him to.

10. APPENDIX B: QUESTIONNAIRE ON CASE OF JOHN

1. Which of the following do you think is most likely:
   (a) John does not have any problem and does not require any treatment.
   (b) This is most likely a religious issue requiring religious assistance.
   (c) This is most likely a psychiatric problem, requiring psychiatric treatment.
   (d) This is a combined psychiatric and religious problem requiring both psychiatric and religious treatment.

2. **If you consider this a psychiatric problem**, which diagnoses would you consider most likely on the basis of the above information?

   _____
   _____
   _____
   _____

3. **If you consider this a psychiatric problem**, how would you describe the problem on the basis of the above information (e.g. brief case formulation)?

   _____
   _____
   _____
   _____

4. **If you consider this a religious problem**, how would you describe the problem on the basis of the above information?

   _____
   _____
   _____
   _____

5. How severely disturbed do you think John is?
   (a) Severely disturbed.
   (b) Moderately disturbed.
   (c) Mildly disturbed.
   (d) Not disturbed at all.

6. How much stress do you think John is experiencing?
   (a) Extreme stress.
   (b) Severe stress.
   (c) Moderate stress.
   (d) Mild stress.
   (e) No stress.

7. How would you rate John's level of maturity?
   (a) Very mature.
   (b) Moderately mature.
   (c) Moderately immature.
   (d) Very immature.

8. Please rank the following options in order of what you feel would be most beneficial to the treatment of John's problem if he has one (1 representing most important, 9 least important).

- ☐ Psychiatric treatment
- ☐ No treatment at all
- ☐ Psychotherapy
- ☐ Spiritual Healing
- ☐ Medication
- ☐ Pastoral Counselling
- ☐ Hospitalisation
- ☐ Prayer and intercession
- ☐ Other _____

9. Would you choose to treat John yourself?
   (a) Yes.
   (b) No.

10. Would you choose to refer John on to another person? If so, please state to whom you would refer.
   (a) Treat him yourself.
   (b) Refer on. To whom? _____
   Profession? _____

11. How responsive and open do you think John would be to you if you were to treat him?
   (a) Very responsive.
   (b) Moderately responsive.
   (c) Minimally responsive.
   (d) Rather unresponsive.
   (e) Very unresponsive.

12. What factors do you think would impact on John's responsiveness to your treatment?

_____

_____

_____

_____

13. How easily do you think you would establish a relationship with John and be empathic with him?
   (a) Easily establish relationship and empathy.
   (b) Establish reasonable relationship and empathy.
   (c) Would have some difficulty establishing relationship and empathy.
   (d) Would find it very difficult to establish relationship and empathy.

14. Why do you think it would be easy/ hard to establish a relationship and empathy with John?

_____

_____

_____

_____

15. How would you rate John's motivation to treatment?
    (a) Highly motivated.
    (b) Moderately motivated.
    (c) Low motivation.
    (d) Completely unmotivated.

16. How would you rate John's level of insight into (or understanding of) any problems that he may have?
    (a) High.
    (b) Moderate.
    (c) Low.
    (d) No insight.

17. How likely do you think it is that John will make substantial progress in treatment with you?
    (a) Very likely.
    (b) Moderately likely.
    (c) Fairly unlikely.
    (d) Not at all.

18. Do you believe a period of hospitalisation would be beneficial to John?
    (a) Would be essential.
    (b) Would be helpful.
    (c) Would make little difference.
    (d) Would be unnecessary.
    (e) Would be undesirable.

19. Do you believe John would benefit from medication?
    (a) Would be essential.
    (b) Would be helpful.
    (c) Would make little difference.
    (d) Would be unnecessary.
    (e) Would be undesirable.

20. If so, which medication would you recommend?
    (a) Uncertain.
    (b) _____

21. Do you think that John's religious beliefs may be causing any pathology, or are they a result of his pathology?
    (a) John's religious beliefs are probably an important causative factor in any pathology.
    (b) John's religious beliefs are probably a minor causative factor in any pathology.
    (c) John's religious beliefs are probably a result of psychiatric difficulties.
    (d) John's religious beliefs are unrelated, by cause or effect, to any pathology.
    (e) John's religious beliefs are normal for the religious group to which he belongs.

22. Do you think it is important for John to change the content of his religious beliefs in order to improve?
    (a) Would be essential.
    (b) Would be helpful
    (c) Would make little difference.
    (d) Would be unnecessary.
    (e) Would be undesirable.

23. Would you directly deal with John's religious beliefs during the course of your consultations, and if so how?
    (a) I would ignore his religious beliefs.
    (b) I would suggest he discuss his religious beliefs with someone else.
    (c) I would discuss his religious beliefs with him.
    (d) I would try to get him to change his religious beliefs.
    (e) I would listen to his religious beliefs but not discuss them.
    (f) Other _____

24. Who do you think would be the most therapeutic type of person for John? Please rank in order of beneficence.

- ☐ A competent psychiatrist regardless of his religious beliefs.
- ☐ A psychiatrist who could share or understand his beliefs.
- ☐ A competent psychologist regardless of his religious beliefs.
- ☐ A psychologist who could share or understand his beliefs.
- ☐ A minister/ pastor who shares his beliefs.
- ☐ A minister/ pastor who is psychologically aware, with good counselling skills.

11. APPENDIX C: PERSONAL QUESTIONNAIRE

1. What is your profession?
   (a) Psychiatrist.
   (b) Registrar.
   (c) Clinical Psychologist.
   (d) Counselling Psychologist.
   (e) Intern Psychologist.
   (f) Pentecostal Pastor/ Minister.
   (g) Other Pastor/Minister
   (h) Other _____

2. For how long have you been qualified or been working in this profession?
   (a) 0-1 year.
   (b) 1-2 years.
   (c) 3-5 years.
   (d) 6-10 years.
   (e) 11-20 years.
   (f) 21-30 years.
   (g) 31-40 years.

3. Into which of the following age groups do you fall?
   (a) 20-29.
   (b) 30-39.
   (c) 40-49.
   (d) 50-59
   (e) 60 and above.

4. What is your sex?
   (a) Female.
   (b) Male.

5. **Psychologists and psychiatrists only**: What theoretical position, if any, do you identify yourself with, concerning psychotherapy?

   _____

6. Which religious group or tradition, if any, do you identify yourself with?

   _____

7. How religious do you consider yourself to be?
   (a) Very religious.
   (b) Moderately religious.
   (c) Vaguely religious.
   (d) Not religious at all.

If you answered not religious at all to the previous question, please skip questions 8 to 27, and resume at question 28.

8. If not prevented by unavoidable circumstances, how often do you attend religious meetings?
   (a) At least once a week.
   (b) Two or three times a month.
   (c) Once a month.
   (d) Rarely
   (e) Never.

9. What religion offers most is comfort when sorrow and misfortune strike.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

10. I try hard to carry my religion over into all my other dealings in life.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

11. One reason for my being a church member is that such membership helps to establish a person in the community.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

12. The purpose of prayer is to secure a happy and peaceful life.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

13. It doesn't matter so much what I believe, as long as I lead a moral life.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

14. Quite often I have been keenly aware of the presence of God or of the Divine being.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

15. My religious beliefs are what really lie behind my whole approach to life.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

16. The prayers I say when I am alone carry as much meaning and personal emotion as those said by me during services.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

17. Although I am a religious person, I refuse to let religious considerations influence my everyday affairs.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

18. The church is most important as a place to formulate good social relationships.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

19. Although I believe in my religion, I feel there are many more important things in life.
   (a) Strongly Agree.
   (b) Agree.
   (c) Uncertain.
   (d) Disagree.
   (e) Strongly Disagree.

20. If I were to join a church group I would prefer to join:
   (a) A Bible study (or such group).
   (b) Uncertain
   (c) A social fellowship.

21. I pray chiefly because I have been taught to pray.
    (a) Strongly Agree.
    (b) Agree.
    (c) Uncertain.
    (d) Disagree.
    (e) Strongly Disagree.

22. Religion is especially important to me because it answers many questions about the meaning of life.
    (a) Strongly Agree.
    (b) Agree.
    (c) Uncertain.
    (d) Disagree.
    (e) Strongly Disagree.

23. A primary reason for my interest in religion is that my church (or religious meeting) is a congenial social activity.
    (a) Strongly Agree.
    (b) Agree.
    (c) Uncertain.
    (d) Disagree.
    (e) Strongly Disagree.

24. I read literature about my faith (or church):
    (a) Frequently.
    (b) Occasionally.
    (c) Rarely.
    (d) Never.

25. Occasionally I find it necessary to compromise my religious beliefs in order to protect my social and economic well being.
    (a) Strongly Agree.
    (b) Agree.
    (c) Uncertain.
    (d) Disagree.
    (e) Strongly Disagree.

26. It is important to me to spend periods of time in private religious thought and meditation.
    (a) Strongly Agree.
    (b) Agree.
    (c) Uncertain.
    (d) Disagree.
    (e) Strongly Disagree.

27. The primary purpose of prayer is to gain relief and protection.
    (a) Strongly Agree.
    (b) Agree.
    (c) Uncertain.
    (d) Disagree.
    (e) Strongly Disagree.

To be answered by all: Which of the following would you do when consulting with a client?

28. Enquire about a client's religious background:
    (a) Never.
    (b) Seldom.
    (c) Frequently.
    (d) Always.

29. Pray with a client:
    (a) Never.
    (b) Seldom.
    (c) Frequently.
    (d) Always.

30. Pray privately for a client:
    (a) Never.
    (b) Seldom.
    (c) Frequently.
    (d) Always.

31. Use religious language or concepts:
    (a) Never.
    (b) Seldom.
    (c) Frequently.
    (d) Always.

32. Use or recommend religious or spiritual books:
    (a) Never.
    (b) Seldom.
    (c) Frequently.
    (d) Always.

33. Recommend participation in religion
    (a) Never.
    (b) Seldom.
    (c) Frequently.
    (d) Always.

12. APPENDIX D: LETTER TO MENTAL HEALTH PROFESSIONALS

Dear _____

Thank you for agreeing to participate in this survey. It should take no more than 30 minutes to complete. I am currently working on my dissertation for my masters in clinical psychology and wish to investigate issues around diagnosis and treatment of clients. In order not to contaminate the findings of this study I do not wish to reveal any more about the exact nature of the research at this time. If you would like more details of the study though, please attach a note to this effect with the completed questionnaire and I will send you out further details.

Please find enclosed a case study, a questionnaire and a self addressed, stamped envelope. Please read the case study thoroughly before opening the questionnaire. Then please respond to the questions on the questionnaire, without returning to change any of your answers at the end. Then please place the questionnaires in the enclosed envelope and return to me as soon as possible.

Once again your participation in this research is greatly valued and appreciated.

Yours sincerely

Supervised by:

ANDREW JOHNSON
INTERN CLINICAL PSYCHOLOGIST

PROF. G C LINDEGGER
CLINICAL PSYCHOLOGIST

13. APPENDIX E: LETTER TO MINISTERS OF RELIGION

Dear _____

Thank you for agreeing to participate in this survey. It should take no more than 30 minutes to complete. I am currently working on my dissertation for my masters in clinical psychology and wish to investigate issues around diagnosis and treatment of clients. In order not to contaminate the findings of this study I do not wish to reveal any more about the exact nature of the research at this time. If you would like more details of the study though, please attach a note to this effect with the completed questionnaire and I will send you out further details.

Please find enclosed a case study, a questionnaire and a self addressed, stamped envelope. Please read the case study thoroughly before opening the questionnaire. Then please respond to the questions on the questionnaire, without returning to change any of your answers at the end. Then please place the questionnaires in the enclosed envelope and return to me as soon as possible.

The questionnaire has been structured to conform to the psychological literature and has used questions from previous research. As a result you may encounter the word "religion" frequently. I acknowledge that this is probably not the best word to describe religious faith, and consequently ask that you understand it to mean "spirituality" as well as more formalised religion.

Once again your participation in this research is greatly valued and appreciated.

Yours sincerely

Supervised by:

ANDREW JOHNSON
INTERN CLINICAL PSYCHOLOGIST

PROF. G C LINDEGGER
CLINICAL PSYCHOLOGIST

14. APPENDIX F: CROSSTAB TABLES SHOWING DIRECTION OF RESULTS FOR MANN WHITNEY AND KRUSKAL WALLIS TEST USED IN ANALYSES.

Table 31: Rankings given to "No Treatment" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	1	1	2
2	2	1	3
3	2	0	2
4	2	0	2
5	3	1	4
6	1	1	2
7	3	3	6
8	9	9	18
9	8	10	18
Total	31	26	57

Table 32: Rankings given to "Psychiatric Treatment" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	3	11	14
2	3	5	8
3	0	3	3
4	4	0	4
5	6	1	7
6	4	2	6
7	3	2	5
8	3	0	3
9	5	2	7
Total	31	26	57

Table 33: Rankings given to "Medication" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	0	1	1
2	0	10	10
3	5	5	10
4	5	2	7
5	6	2	8
6	2	1	3
7	6	2	8
8	3	1	4
9	4	2	6
Total	31	26	57

Table 34: Rankings given to "Hospitalization" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	0	3	3
2	1	1	2
3	2	3	5
4	0	2	2
5	2	3	5
6	4	5	9
7	7	4	11
8	8	2	10
9	7	3	10
Total	31	26	57

Table 35: Rankings given to "Psychotherapy" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	2	7	9
2	6	5	11
3	3	6	9
4	3	5	8
5	3	2	5
6	7	0	7
7	1	0	1
8	2	0	2
9	4	1	5
Total	31	26	57

Table 36: Rankings given to "Pastoral Counselling" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	18	1	19
2	6	3	9
3	4	3	7
4	2	10	12
5	0	6	6
6	1	0	1
7	0	0	0
8	0	0	0
9	0	3	3
Total	31	26	57

Table 37: Rankings given to "Spiritual Healing" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	1	0	1
2	4	1	5
3	6	2	8
4	6	3	9
5	5	3	8
6	4	3	7
7	3	5	8
8	0	4	4
9	2	5	7
Total	31	26	57

Table 38: Rankings given to "Intercession" by Type as most beneficial form of treatment (Q8).

	Minister	Mental Health Profession	Total
1	1	0	1
2	7	0	7
3	7	2	9
4	4	2	6
5	4	3	7
6	3	8	11
7	2	3	5
8	0	1	1
9	3	7	10
Total	31	26	57

Table 39: Table of Profession by No Treatment

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	0	1	1	0	2
2	2	0	1	0	3
3	0	2	0	0	2
4	2	0	0	0	2
5	1	2	1	0	4
6	1	0	0	1	2
7	1	2	2	1	6
8	3	6	8	1	18
9	3	5	4	6	18
Total	13	18	17	9	57

Table 40: Table of Profession by Psychiatric Treatment

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	0	3	4	7	14
2	0	3	4	1	8
3	0	0	2	1	3
4	1	3	0	0	4
5	4	2	1	0	7
6	2	2	2	0	6
7	1	2	2	0	5
8	1	2	0	0	3
9	4	1	2	0	7
Total	13	18	17	9	57

Table 41: Table of Profession by Medication

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	0	0	1	0	1
2	0	0	3	7	10
3	0	5	3	2	10
4	4	1	2	0	7
5	2	4	2	0	8
6	0	2	1	0	3
7	4	2	2	0	8
8	0	3	1	0	4
9	3	1	2	0	6
Total	13	18	17	9	57

Table 42: Table of Profession by Hospitalisation

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	0	0	1	2	3
2	0	1	0	1	2
3	2	0	0	3	5
4	0	0	0	2	2
5	0	2	2	1	5
6	3	1	5	0	9
7	1	6	4	0	11
8	4	4	2	0	10
9	3	4	3	0	10
Total	13	18	17	9	57

Table 43: Table of Profession by Psychotherapy

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	0	2	7	0	9
2	0	6	5	0	11
3	2	1	3	3	9
4	1	2	0	5	8
5	3	0	1	1	5
6	3	4	0	0	7
7	0	1	0	0	1
8	1	1	0	0	2
9	3	1	1	0	5
Total	13	18	17	9	57

Table 44: Table of Profession by Pastoral Counselling

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	8	10	1	0	19
2	2	4	3	0	9
3	3	1	3	0	7
4	0	2	8	2	12
5	0	0	1	5	6
6	0	1	0	0	1
7	0	0	0	0	0
8	0	0	0	0	0
9	0	0	1	2	3
Total	13	18	17	9	57

Table 45: Table of Profession by Spiritual Healing

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	0	1	0	0	1
2	3	1	1	0	5
3	4	2	2	0	8
4	2	4	3	0	9
5	2	3	3	0	8
6	0	4	2	1	7
7	1	2	1	4	8
8	0	0	3	1	4
9	1	1	2	3	7
Total	13	18	17	9	57

Table 46: Table of Profession by Prayer and Intercession

	Pentecostal Minister	Mainstream Minister	Psychologist	Psychiatrist	Total
1	1	0	0	0	1
2	5	2	0	0	7
3	3	4	2	0	9
4	0	4	2	0	6
5	1	3	3	0	7
6	0	3	4	4	11
7	1	1	3	0	5
8	0	0	0	1	1
9	2	1	3	4	10
Total	13	18	17	9	57

Table 47: Table of Type of profession by "Psychiatrist" as therapeutic person.

	Ministers	Mental Health Professionals	Total
1		4	4
2		4	4
3	1	3	4
4	5		5
5	6	4	10
6	19	11	30
Total	31	26	57

Table 48: Table of Type of profession by "Psychiatrist with same beliefs" as therapeutic person.

	Ministers	Mental Health Professionals	Total
1	3	10	13
2	2		2
3	6	3	9
4	10	2	12
5	1	3	4
6	9	8	17
Total	31	26	57

Table 49: Table of Type of profession by "Psychologist" as therapeutic person.

	Ministers	Mental Health Professionals	Total
1	3	3	6
2		5	5
3	2	1	3
4	3	6	9
5	12	3	15
6	11	8	19
Total	31	26	57

Table 50: Table of Type of profession by "Psychologist with same beliefs" as therapeutic person.

	Ministers	Mental Health Professionals	Total
1	3	8	11
2	13	5	18
3	9	2	11
4		3	3
5		1	1
6	6	7	13
Total	31	26	57

Table 51: Table of Type of profession by "Minister with same beliefs" as therapeutic person.

	Ministers	Mental Health Professionals	Total
1	3		3
2	6		6
3	1	3	4
4	3	3	6
6	18	20	38
Total	31	26	57

Table 52: Psychiatrist as therapeutic person by ROS for mental health professionals.

Ranking	Intrinsic	Indiscriminate	Non-religious	Total
1	1	2	1	4
2	0	0	4	4
3	1	0	2	3
4	0	0	0	0
5	3	0	1	4
6	6	3	2	11
Total	11	5	10	26

Table 53: Psychiatrist with same beliefs as therapeutic person by ROS for mental health professionals.

Ranking	Intrinsic	Indiscriminate	Non-religious	Total
1	3	2	5	10
2	0	0	0	0
3	2	1	0	3
4	1	0	1	2
5	1	0	2	3
6	4	2	2	8
Total	11	5	10	26

Table 54: Minister with same beliefs as therapeutic person by ROS for mental health professionals.

Ranking	Intrinsic	Indiscriminate	Non-religious	Total
1	0	0	0	0
2	0	0	0	0
3	2	0	1	3
4	1	1	1	3
5	0	0	0	0
6	8	4	8	20
Total	11	5	10	26

Table 55: Minister with counselling skills as therapeutic person by ROS for mental health professionals.

Ranking	Intrinsic	Indiscriminate	Non-religious	Total
1	1	0	0	1
2	4	1	1	6
3	1	0	3	4
4	1	0	1	2
5	1	0	3	4
6	3	4	2	9
Total	11	5	10	26

Table 56: No Treatment by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	0	0	1	1
2	1	0	0	1
3	0	0	0	0
4	0	0	0	0
5	1	0	0	1
6	0	1	0	1
7	1	0	2	3
8	6	0	3	9
9	2	4	4	10
Total	11	5	10	26

Table 57: Psychiatric Treatment by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	4	2	5	11
2	2	1	2	5
3	2	0	1	3
4	0	0	0	0
5	0	0	1	1
6	2	0	0	2
7	1	0	1	2
8	0	0	0	0
9	0	2	0	2
Total	11	5	10	26

Table 58: Medication by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	1	0	0	1
2	3	2	5	10
3	2	1	2	5
4	1	0	1	2
5	2	0	0	2
6	0	0	1	1
7	1	0	1	2
8	1	0	0	1
9	0	2	0	2
Total	11	5	10	26

Table 59: Hospitalization by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	0	2	1	3
2	1	0	0	1
3	0	2	1	3
4	1	0	1	2
5	1	0	2	3
6	2	0	3	5
7	4	0	0	4
8	1	0	1	2
9	1	1	1	3
Total	11	5	10	26

Table 60: Psychotherapy by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	4	0	3	7
2	2	1	2	5
3	3	1	2	6
4	0	3	2	5
5	2	0	0	2
6	0	0	0	0
7	0	0	0	0
8	0	0	0	0
9	0	0	1	1
Total	11	5	10	26

Table 61: Pastoral Counselling by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	0	1	0	1
2	2	0	1	3
3	2	0	1	3
4	6	0	4	10
5	0	2	4	6
6	0	0	0	0
7	0	0	0	0
8	0	0	0	0
9	1	2	0	3
Total	11	5	10	26

Table 62: Healing by ROS for mental health professionals.

Rank	Intrinsic	Indiscriminate	Non-religious	Total
1	0	0	0	0
2	0	1	0	1
3	0	0	2	2
4	2	0	1	3
5	2	0	1	3
6	2	0	1	3
7	2	2	1	5
8	2	0	2	4
9	1	2	2	5
Total	11	5	10	26

Table 63: Disturbance by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Severely Disturbed	2	2	2	6
Moderately Disturbed	6	2	7	15
Mildly Disturbed	2	1	1	4
Not disturbed at all	1			1
Total	11	5	10	26

Table 64: Stress by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Severe Stress	2			2
Moderate Stress	4	3	5	12
Mild Stress	3	1	5	9
No Stress	2	1		3
Total	11	5	10	26

Table 65: Maturity by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Very Immature	3	2	1	6
Moderately Immature	7	1	9	17
Moderately Mature	1	2		3
Total	11	5	10	26

Table 66: Level of Responsiveness to treatment by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Moderately Responsive	3	1	1	5
Minimally Responsive	3	2	5	10
Rather Unresponsive	4	0	4	8
Very Unresponsive	1	2	0	3
Total	11	5	10	26

Table 67: Degree of Motivation to treatment by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Moderately motivated	0	0	1	1
Low motivation	7	2	7	16
Completely unmotivated	4	3	2	9
Total	11	5	10	26

Table 68: Level of Insight by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Moderate	1	0	0	1
Low	7	1	6	14
No Insight	3	4	4	11
Total	11	5	10	26

Table 69: Expected Progress by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Very likely	0	1	0	1
Moderately likely	7	1	7	15
Fairly unlikely	3	3	1	7
Not at all	0	0	1	1
Total	10	5	9	24

Table 70: Need to change Beliefs by ROS for mental health professionals.

	Intrinsic	Indiscriminate	Non-religious	Total
Would be essential	1	2	4	7
Would be helpful	6	2	2	10
Would make little difference	0	1	3	4
Would be unnecessary	3	0	0	3
Would be undesirable	0	0	1	1
Total	10	5	10	25

15. APPENDIX G: ANALYSIS OF RELIGIOUS VARIABLES.

Table 71: Analysis of Religious Orientation with Actual Medians using Kruskal Wallis H-test:

Variable	Chi-Square	Degrees of Freedom	Significance Level
Degree of Disturbance (Q5)	3.85	3	0.28
Degree of Stress (Q6)	3.92	3	0.27
Degree of Maturity (Q7)	1.21	3	0.75
No Treatment	3.82	3	0.28
Psychiatric Treatment	4.64	3	0.20
Medication	1.24	3	0.74
Hospitalization	6.86	3	0.08
Psychotherapy	2.95	3	0.40
Pastoral Counselling	5.59	3	0.13
Healing	3.58	3	0.31
Intercession	6.92	3	0.07
Responsiveness (Q11)	1.54	3	0.67
Level of Motivation (Q15)	1.67	3	0.64
Degree of Insight (Q16)	3.31	3	0.35
Likelihood of Progress (Q17)	0.42	3	0.94
Need for Hospital (Q18)	6.73	3	0.08
Need for Medication (Q19)	2.51	3	0.47
Need to change Beliefs (Q22)	4.79	3	0.19
Psychiatrist as therapeutic person	2.15	3	0.54
Psychiatrist with same beliefs as therapeutic person	7.42	3	0.06
Psychologist as therapeutic person	5.31	3	0.15
Psychologist with same beliefs as therapeutic person	2.62	3	0.45
Minister with same beliefs as therapeutic person	0.18	3	0.98
Minister with counselling skills as therapeutic person	0.63	3	0.89
Most beneficial Person (Q24)	6.46	3	0.09

Table 72: ROS with Adjusted Medians for Mental Health Professionals by Problem.

	Intrinsic	Extrinsic	Indiscriminate	Non Religious	Total
No problem	1	0	0	1	2
Religious issue	0	0	0	1	1
Psychiatric problem	0	2	5	3	10
Combined psychiatric and religious problem	5	3	3	2	13
Total	6	5	8	7	26

Table 73: ROS with Adjusted Medians for Mental Health Professionals by First Choice of Treatment.

	Intrinsic	Extrinsic	Indiscriminate	Non Religious	Total
Religious Treatment	1	0	1	0	2
Psychological or Psychiatric Treatment	5	5	7	6	23
Total	6	5	8	6	25

Table 74: ROS with Adjusted Medians for Mental Health Professionals by Most beneficial Profession.

	Intrinsic	Extrinsic	Indiscriminate	Non-religious	Total
Psychiatrist	2	5	4	3	14
Psychologist	3		4	4	11
Minister	1				1
Total	6	5	8	7	26

Table 75: ROS with Adjusted Medians for Mental Health Professionals by Role of Beliefs.

	Intrinsic	Extrinsic	Indiscriminate	Non Religious	Total
Beliefs are a causative factor in any difficulties	0	2	1	1	4
Beliefs are result of his difficulties	4	3	6	4	17
Beliefs are normal/unrelated to any difficulties	1	0	1	2	4
Total	5	5	8	7	25

Table 76: ROS with Adjusted Medians for Mental Health Professionals by Dealing with Beliefs.

	Intrinsic	Extrinsic	Indiscriminate	Non-religious	Total
Discuss his religious beliefs with him	4	2	3	3	12
Try to get him to change his religious beliefs	1	2	0	0	3
Listen to his religious beliefs but not discuss them	1	1	5	4	11
Total	6	5	8	7	26