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SPIRITUAL THERAPY FOR MENTAL DISORDERS

HEALTH TECHNOLOGY ASSESSMENT SECTION (MaHTAS)
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DISCLOSURE

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EXECUTIVE SUMMARY

Introduction

During the 20th century, medicine, religion and science were considered by the academic, scientific and medical communities to be separate realms of thought whose presentation in the same text leads to misunderstanding of both. Religiousness was labelled “equivalent to irrational thinking and emotional disturbance”.

It has now been demonstrated that such notions were not based on any scientific evidence but rather on non-evidence-based clinical impressions. Research indicated that religiosity (religious activities, religious beliefs), spiritual beliefs and practices were widespread among American population and that these beliefs and practices had clinical relevance. Therefore, towards the end of the 20th century, professional organizations increasingly called for greater sensitivity and better training of clinicians concerning the management of religious and spiritual issues in the assessment and treatment of these patients; these organizations included the American Psychiatric Association in 1989, the American Psychological Association 1992, The accreditation Council for graduate Medical Education in 1994, The Council on Social Work Education in 1995, the Joint Commission on Accreditation of Healthcare Organization in 1996, The American Academy of Family Physicians (AAFP) in 1997, the American College of Physicians in 1998 and the Association of American Medical Colleges in 1998.

In Islam, the term spirituality is inseparable from the awareness of the One, of Allah (God), and a life lived according to His Will. This principle of Oneness (Al-tawheed – unity) must be taken into consideration in any study of Islamic spirituality. Culliford mentioned that ‘many reports give less importance to beliefs and to faith’. However, for Muslims the Qur’an ‘is a guide and gives healing to those who believe’ (Chapter 41, verse 44). The religion and the tradition of an individual’s faith therefore plays an important and very significant role in satisfying the physical as well as the spiritual needs of human beings. Culliford mentioned also that, unfortunately, religious, moral and ethical values have been declining in today’s society. Families are falling apart, crime and the divorce rate are increasing sharply, and substance misuse and excessive sexual indulgence are common in adolescents and young adults. These factors lead to conflicts, resentment and the loss of self-respect, loneliness, depression, anxiety and a host of psychological symptoms. Sajid A, Baloch SO and Din H mentioned that the Islamic principles that are based on the Qur’an and Hadith are the best form of prevention and treatment of many diseases including emotional disturbances and depression. Culliford makes an important point about spiritual needs and spiritual care. From the Islamic point of view, one approach to disease management is the use of *dua* – prayer from the Qur’an (Chapter 17, verse 82) and Hadith (sayings of the Holy Prophet (peace be upon him). The Qur’an is the best medicine*. Dua*- prayer from the Qur’an is medicine. There should be no dichotomy between the spiritual and physical. Both approaches should be used for the same constitution. Each cures the disease using a different pathway. There is no contradiction but there is always synergy. According to Sajid A, it is a mistake to use one and reject the other. This technology was requested by the Director of the Traditional and Complementary Medicine Division, Ministry of Health, Malaysia to look into the evidence on Spiritual Therapy that encompasses religiosity.

Objective/aim

The objective of this systematic review was to assess the efficacy / effectiveness, safety and economic implication of spiritual therapy as a complement therapy to standard

treatment for patients with mental disorders such as anxiety, depression, schizophrenia, mental stress, insomnia or headache.

Results and conclusions

A total of 1105 titles were identified through the Ovid interface and PubMed. Eight articles related to the effect of spiritual therapy on mental disorders were included in this review consisting of one systematic review and seven cross sectional studies. The studies were conducted in United States and United Kingdom.

The majority of the studies were of observational, cross-sectional design which did not allow drawing any definitive conclusions about the causal relationships of the variables. Most of the studies are limited by the nature of the population studied and short duration of study. However, a systematic review showed that Intercessory prayer (IP) may improve health outcomes by lowering severity scores of patients, Islamic-based psychotherapy and religious activities speeds recovery from anxiety and depression in Muslim patients. Most of the studies showed that involvement in religious activities, religious beliefs, spiritual beliefs and practices may promote mental and physical health such as lowering the scores in depression and anxiety. Most of the findings suggested potential benefit namely religious quality involvement was protective through personal and meditative aspects for depression anxiety and schizophrenia. However, the long term effects of spiritual therapy for mental health disorders could not be determined. Hence, there is a need for more research in this area to gauge the beneficial effect of spiritual therapy and religiosity (aspects of religious activity, dedication, and belief), spiritual beliefs and practices has on health outcomes as an adjunctive treatment in patients with mental disorders such as anxiety, depression and schizophrenia.

Methods

Electronic databases were searched through the Ovid interface: Ovid MEDLINE® In-process and other Non-indexed citations and Ovid MEDLINE® 1948 to present, EBM Reviews - Cochrane Central Register of Controlled Trials – Mac 2015, EBM Reviews - Cochrane Database of Systematic Reviews - 2000 to Mac 2015, EBM Reviews - Health Technology Assessment – 1st Quarter 2015, EBM Reviews - Database of Abstracts of Reviews of Effects – 1st Quarter 2015, Embase – 1988 to 2015 week 10. Searches were also run in PubMed. Google was used to search for additional web-based materials and information. Additional articles were identified from reviewing the references of retrieved articles. Last search was conducted on 9th Mac 2015.

SPIRITUAL THERAPY FOR MENTAL DISORDERS

1. INTRODUCTION

During the 20th century, medicine, religion and science were considered by the academic, scientific and medical communities to be separate realms of thought whose presentation in the same text leads to misunderstanding of both. Religiousness was labelled “equivalent to irrational thinking and emotional disturbance”.[1-3]

It has now been demonstrated that such notions were not based on any scientific evidence but rather on non-evidence-based clinical impressions. Research indicated that religiosity (religious activities, religious beliefs), spiritual beliefs and practices were widespread among American population and that these beliefs and practices had clinical relevance. Therefore, towards the end of the 20th century, professional organizations increasingly called for greater sensitivity and better training of clinicians concerning the management of religious and spiritual issues in the assessment and treatment of these patients; these organizations included the American Psychiatric Association in 1989, the American Psychological Association 1992, The accreditation Council for graduate Medical Education in 1994, The Council on Social Work Education in 1995, the Joint Commission on Accreditation of Healthcare Organization in 1996, The American Academy of Family Physicians (AAFP) in 1997, the American College of Physicians in 1998 and the Association of American Medical Colleges in 1998.[1]

A random survey of almost 300 physicians at the 1996 meeting of the AAFP revealed that 99% believed that spiritual well-being can promote health and healing. Seventy-five percent believed that others’ prayers could promote healing.[1, 4] While the significance of spirituality in substance abuse treatment has been acknowledged for many years due to widespread recognition of the therapeutic value of 12-step programs, this is a new development in the treatment of serious mental disorders such as bipolar disorder and schizophrenia.[5-6] The incorporation of spirituality into treatment is part of the recovery model which has become widely accepted in the US and around the world.[5] Several studies document those patients with serious mental disorders use religion to cope with their illness [7] and that the intensity of religious beliefs is not associated with psychopathology.[8] In many cases, religious practices (such as worship and prayer) appear to protect against severity of psychiatric symptoms and hospitalization, and enhance life satisfaction and speed recovery in mental disorders. [9]

In Islam, the term spirituality is inseparable from the awareness of the One, of Allah (God), and a life lived according to His Will. This principle of Oneness (Al-tawheed – unity) must be taken into consideration in any study of Islamic spirituality.[12] Culliford mentioned that ‘many reports give less importance to beliefs and to faith’.[11] However, for Muslims the Qur’an ‘is a guide and gives healing to those who believe’ (Chapter 41, verse 44).[12-14] The religion and the tradition of an individual’s faith therefore plays an important and very significant role in satisfying the physical as well as the spiritual needs of human beings. Culliford mentioned also that, unfortunately, religious, moral and ethical values have been declining in today’s society.[11, 12] Families are falling apart, crime and the divorce rate are increasing sharply, and substance misuse and excessive sexual indulgence are common in adolescents and young adults. These factors lead to conflicts, resentment and the loss of self-respect, loneliness, depression, anxiety and a host of psychological symptoms.[11, 12] Sajid A, Baloch SO and Din H mentioned that the Islamic principles that are based on the

Qur'an and Hadith are the best form of prevention and treatment of many diseases including emotional disturbances and depression.[12-14] Culliford makes an important point about spiritual needs and spiritual care. From the Islamic point of view, one approach to disease management is the use of *dua* – prayer from the Qur'an (Chapter 17, verse 82) and Hadith (sayings of the Holy Prophet (peace be upon him). [12-14] The Qur'an is the best medicine*. Dua*- prayer from the Qur'an is medicine.[12-14]There should be no dichotomy between the spiritual and physical. Both approaches should be used for the same constitution.[12]Each cures the disease using a different pathway. There is no contradiction but there is always synergy. According to Sajid A, it is a mistake to use one and reject the other.[12] This technology was requested by the Director of the Traditional and Complementary Medicine Division, Ministry of Health, Malaysia to look into the evidence on Spiritual Therapy that encompasses religiosity.

2. OBJECTIVE / AIM

The objective of this systematic review was to assess the efficacy / effectiveness, safety and economic implication of spiritual therapy as a complement therapy to standard treatment for patients with mental disorders such as anxiety, depression, schizophrenia, mental stress, insomnia or headache.

3. TECHNICAL FEATURES

Spiritual therapy is a form of counseling or psychotherapy that involves moral, spiritual, and religious influences on behavior and physical health. It is the use of spiritual and religious beliefs and values to strengthen the self. Spiritual healing is the use of spiritual practices, such as prayer, for the purpose of affecting a cure of or an improvement in an illness. Spirituality therapy focuses on all matters relating to spirituality and the individual and the application of spirituality into the day to day life. Most of the time, people seek out the counsel of their religious leaders. Randal et al mentioned that spiritual therapy includes supportive therapy, focus on recovery, spirituality, and cognitive-behavioral therapy, as well as psycho-education and affective regulation. Of special note is the spiritual focus of the treatment.[10]

Religiosity, in its broadest sense, is a comprehensive sociological term used to refer to the numerous aspects of religious activity, dedication, and belief (religious doctrine). Another term that would work equally well, though less often used, is *religiousness*.

4. METHODS

4.1. Searching

Electronic databases were searched through the Ovid interface: Ovid MEDLINE® In-process and other Non-indexed citations and Ovid MEDLINE® 1948 to present, EBM Reviews - Cochrane Central Register of Controlled Trials – Mac 2015, EBM Reviews - Cochrane Database of Systematic Reviews - 2000 to Mac 2015, EBM Reviews - Health Technology Assessment – 1st Quarter 2015, EBM Reviews - Database of Abstracts of Reviews of Effects – 1st Quarter 2015, Embase – 1988 to 2015 week 10. Searches were also run in PubMed. Google was used to search for additional web-based materials and

information. Additional articles were identified from reviewing the references of retrieved articles. Last search was conducted on 9th Mac 2015.

Appendix 1 showed the detailed search strategies.

4.2. Selection

A reviewer screened the titles and abstracts against the inclusion and exclusion criteria and then evaluated the selected full text articles for final article selection.

The inclusion and exclusion criteria were:

Inclusion criteria

Population	Patients with Mental disorders, Mental Stress, Schizophrenia, Psychotic disorders, Depressive Disorder, Depression, anxiety
Interventions	Spiritual therapy, Faith healing, Spirituality religiosity
Comparators	Normal practice, placebo
Outcomes	Reduction in: psychological factors, depression, anxiety, fear, anger, tormenting thoughts, mental stress, schizophrenia,
Study design	Health Technology Assessment (HTA), Systematic Review, Randomised Controlled Trial (RCT), Non Randomised Controlled Trial, cross sectional studies,
	English full text articles

Exclusion criteria

Study design	Studies conducted in animals and narrative reviews
	Non English full text articles

Relevant articles were critically appraised using Critical Appraisal Skills Programme (CASP) and graded according to US/Canadian preventive services task force (Appendix 2). Data were extracted and summarised in evidence table as in Appendix 3.

5. RESULTS AND DISCUSSION

A total of 1105 titles were identified through the Ovid interface and PubMed. Eight articles related to the effect of spiritual therapy on mental disorders were included in this review consisting of one systematic review and seven cross sectional studies. The studies were conducted in United States and United Kingdom.

5.1. SAFETY

There was no retrievable evidence on safety.

5.2 Effectiveness

5.2.1 Depressive disorder

Townsend et al did a systematic review to assess the impact of religion on health outcomes.[15 level 1] All RCT's published from 1966 to 1999 and all non-RCT's published from 1996 to 1999 that assessed a relationship between religion and measurable health outcome were examined. Nine randomised controlled trials (RCT's) and twenty-five non-RCT's met the inclusion criteria. Results:

- Intercessory prayer (IP) may improve health outcomes in patients admitted to a coronary care unit but showed no effect on alcohol abuse
    - Christian prayer results in 10% better outcomes in intervention group
    - The IP group subsequently had a significantly lower severity score based on the hospital course after entry ($P < .01$).
- Islamic-based psychotherapy speeds recovery from anxiety and depression in muslims
    - 3 RCT's evaluated the effect of islam-based psychotherapy on religious malay muslims. Patients who fulfilled the criteria for anxiety or depression were given religious psychotherapy (advice, encouragement based on the Koran and Hadith) in addition to traditional psychotherapy.
    - The results revealed that spritual islamic-based psychotherapy (SIPT) had more efficacy than medication based on both scales ($P < 0.01$); however, it was not different from cognative behavariol therapy (CBT). SIPT was more effective on the modification of dysfunctional attitudes compared with CBT and medication ($P < 0.05$).

Non-RCT's indicate that religious activities appear to benefit blood pressure, immune function, depression and mortality

Ellison CG et al did cross sectional study in the United States whereby the data from the National Survey of Black Americans (NSBA), a nationwide longitudinal survey of African American adults conducted by the Survey Research Center at the University of Michigan in 1979–1980, 1987–1988, 1988–1989, and 1992 was used.[16 level III] After adjustments of cases with missing values on key variables, the effective sample size was 607. Information on depression was collected via the NIMH Diagnostic Interview Schedule, which gauged the presence, severity, and duration of symptoms. Major depression during the past 12 months was measured as a dichotomous variable (case = 1, no case = 0), based on DSM-III Diagnostic criteria. To be classified as depressed, after responding affirmatively to a screening question, respondents must have had at least 3 depressive symptoms and must also have met severity criteria. Aspects of religious involvement, which were measured at T1: religious attendance, religious guidance, and social support from church members. Findings are presented as odds ratios (OR). Bivariate associations between the Religious Variables (T1) and Major Depression (T2) were measured:

- the odds of major depression were roughly 50% lower (OR = 0.49, $p = 0.05$) among persons who report "a great deal" of guidance from religion in their day-to-

day lives, as compared with those persons who received less guidance from their religion.

- The odds of T2 major depression were reduced by roughly half (OR = 0.47, p = 0.05) for African Americans aged 55, as compared with younger participants, and by roughly half (OR = 0.47, p = 0.05) for respondents whose baseline family income fell in the top one-third of the distribution, as compared with their less affluent counterparts.
- Logistic regression found that survey participants who reported receiving "a great deal" of guidance from religion in their day-to-day lives at Time 1 (1988 –1989) were roughly half as likely (OR = 0.47, p= 0.01) to have major depression at Time 2 (1992), controlling for socio demographic and psychological factors, and major depression at baseline. The odds of major depression were also lower for persons with high self-esteem (OR= 0.41, p= 0.01) and those who reported having satisfying relationships with friends and family members (OR = 0.51, p = 0.05) at baseline.
- No association was found between religious attendance or church support and major depression.

Daaleman TP et al did a study to examine the association of spirituality and symptoms of depression in primary care outpatients.[17 level III] A cross-sectional analysis was performed on a dataset using 509 primary care outpatients who participated in instrument validity study in the Kansas City, US area. Patients were administered the Zung Depression Scale (ZDS) and the Spirituality Index of Well-Being (SIWB) in the waiting area before or after their appointment. Bivariate and multivariate analyses were performed to determine the relationship between the factors of interest and depressive symptoms. Subjects were eligible if they were 18 years of age or older, English speaking, had no discernable cognitive impairment as determined by study personnel, and were willing to participate in the study. Results were as follows:

- A total of 550 subjects were approached and 509 patients participated in the study. A total of 15 patients (3%) of the sample population reported depressive symptoms based on summed Zung Depression Scale scores of 50 or greater.
- In bivariate analyses, less insurance coverage (P < 0.01) and greater spirituality (P < 0.01) were associated with less reported depressive symptoms.
- In a model adjusted for covariates, spirituality (P < 0.01) remained independently associated with less depressive symptoms OR= 0.85 (95% CI; 0.80, 0.91)

Hence, the authors suggested that primary care outpatients who report greater spirituality are more likely to report less depressive symptoms.

Koenig HG did a cross sectional study with the purpose to examine the impact of patient characteristics on the course of depression in patients hospitalized with congestive heart failure and chronic pulmonary disease (CHF and/or CPD).[18 level III] Between 1999 and 2003, research nurses assessed consecutive medical inpatients with CHF/ CPD over age 50 admitted to Duke University Medical Center, Durham (DUMC) or three nearby smaller community hospitals. Patients were screened for depressive disorder using the Structured Clinical Interview for *DSM–IV* (SCID-I/NP, version 2.0). Data were collected only on patients identified with depressive disorder. Severity of depression was determined using the 17-item Hamilton Depression Rating Scale (HDRS) (range: 0–52). Severity of CHF/CPD was assessed using the dyspnea subscale of the Chronic Heart Failure/ Chronic

Pulmonary Disease Questionnaire. Religious characteristics examined were religious affiliation, spiritual–religious self-categorizations, public and private religious activities, and intrinsic religiosity. Religious affiliation was grouped into seven categories: 1) Protestant unspecified, 2) Reformation Protestant (i.e., Presbyterian, Lutheran, Episcopalian), 3) Pietistic Protestant (i.e., Methodist, Baptist, Christian), 4) Neofundamentalist Protestant (i.e., Church of God, Pentecostal Holiness, Southern Baptist), 5) Catholic, 6) nontraditional Christian and other religions (Jehovah Witnesses, Jewish, Muslim, and so on), and 7) no affiliation. Patients were then asked to categorize themselves as 1) spiritual but not religious, 2) religious but not spiritual, 3) both religious and spiritual, and 4) neither religious nor spiritual ("spiritual" and "religious" left to the patient to define).

One thousand patients with CHF only (N=174), CPD only (N=527), or both (N=299) were identified with depressive disorder, out of which 505 from DUMC and 495 from community hospitals. Of these, 59% had minor depression and 41% had major depression. Both disorders required current impairment of psychological, social, or occupational functioning. Results showed that:

- Patients with no religious affiliation were 12.7 and 10.3 times more likely to have major and minor depression, respectively, than patients with an affiliation.
- Neofundamentalists, however, were 84% and 83% less likely to have major and minor depression, respectively.
- Patients who considered themselves spiritual but not religious were 4.5 and 3.7 times more likely to have major and minor depression, respectively.
- Those who indicated they were both spiritual and religious were approximately 80% less likely to have depressive disorder.
- There was no relationship between depression and religious attendance or other group religious activity.
- Patients who prayed at least once a day were only half as likely to experience major and minor depression (48% and 54%, respectively).
- Patients who watched religious TV or listened to religious radio at least several times per week were 35% less likely to have minor depression.
- Patients who scored higher on intrinsic religiosity were less likely to have major depression (3% reduction for every one-point higher) and especially less likely to have minor depression (4% reduction for every one-point higher).
- After controlling for demographic and physical health factors, depressed patients were more likely to indicate no religious affiliation, less likely to affiliate with neofundamentalist denominations, more likely to indicate "spiritual but not religious," less likely to pray or read scripture, and scored lower on intrinsic religiosity. Among depressed patients, there was no relationship between religion and depression type, but depression severity was associated with a lower religious attendance, prayer, scripture reading, and lower intrinsic religiosity. Social factors only partially explained these relationships.
- Older medically ill hospitalized patients with depression are less religiously involved than nondepressed patients or those with less severe depression.

Cruz M et al, did a cross sectional study whereby the authors assessed the association between public and private religious participation and depression as well as hopelessness in older depressed, adults treated in mental health settings.[19] [level III] Data from 130 participants from a post treatment longitudinal follow-up study of late-life depression were

analyzed. Treatment study participants were recruited from the geriatric inpatient units and outpatient clinics at the Western Psychiatric Institute and Clinic, Pittsburgh. Multiple regressions analyses were performed to assess the association between public (frequency of church attendance) and private (frequency of prayer/meditation) forms of religious participation and depression as well as hopelessness severity when demographic and health indicators were controlled. Results showed that:

- Twenty-nine participants scored 9 or above on the Beck Hopelessness Scale (BHS)and 41 participants' scored 7 or less on the post treatment Hamilton Rating Scale for Depression(HRSD)
- 92% of participants reported a religious affiliation with 60% of participants reporting attending church at least once a week (mode = 5) and 84% reporting privately praying or meditating at least every day (mode = 6).
- Multivariate analyses found significant negative associations between frequency of prayer /meditation and depression (OR = 0.56 [0.36–0.89], as well as hopelessness severity (OR = 0.58 [0.36–0.94].
- male gender was significantly associated with hopelessness (OR = 2.79 [1.03–7.48],
- prayer was significantly associated with less hopelessness (OR = 0.58 [0.36–0.94 and reduced depression severity scores (OR= 0.56 [0.36–0.89],
- Church attendance was not significantly associated with depression (OR= 0.914 [0.70 –1.189], or hopelessness (OR= 0.78 [0.58– 1.04]
- Hence, frequency of prayer or meditation but not church attendance predicted lower hopelessness and depression severity scores in older adults treated for depression in mental health settings

This study supported significant, direct relationships between prayer/meditation and depression as well as hopelessness severity in older adults treated for depression in mental health settings. Prospective studies are needed to further illuminate these relationships.

5.2.2 Anxiety

Hurst GA et al did a cross sectional study whereby thirty three individuals who attended a Living Free in Christ Conference in Edmond, Oklahoma or in Tyler, Texas were given a 12-item Likert scale questionnaire designed to test whether a faith-based intervention would have a positive effect in individuals with a variety of emotional/ mental and behavioral difficulties. [20 level III] The selection of the individuals were made on the basis of the following priorities: (1) presence of significant depression including suicidal tendencies, anxiety, and other typical presenting problems; (2) Availability of the client during the three days following the conference. The individuals (n=33) were later given appointments with counselors. *Each Step to Freedom* appointment uses prayers to ask forgiveness and have faith in God to enable clients to address and resolve past and present personal and spiritual problems. *Steps to Freedom* appointments were offered free of charge and lasted approximately 6 or 7 hours. In discipleship counseling literature, the lay counselors are referred to as encouragers and clients are referred to as counselees. Later, another post-appointment questionnaire with a self-addressed stamped envelope was mailed 3 to 4 months later to each client. In Texas, each client and comparison (control) member was also given the SCL-90-R questionnaire along with the 12-item questionnaire. The lengthy SCL-90-R questionnaire has been subjected to extensive research, and has demonstrated scientifically acceptable validity and reliability. A comparison "control" group consisted of

volunteers (n=18) who attended the Tyler, Texas, host church on the Sunday after the conclusion of the conference. These individuals had not attended the conference and had never gone through the *Steps to Freedom*. Results were as follows:

- The post counseling percentage decrease (improvement), in symptom/behavior (Changes were significant at P ≤ 0.005 using the Wilcoxon matched pairs test) was: - 49% for depression, - 44% for anxiety, - 49% for fear (irrational), - 45% for anger (unhealthy), - 42% for tormenting thoughts and voices, and -46% for habits and behavior
- Significant changes *P* ≤ 0.05 (improvement) occurred in all six of the function areas. The greatest percent improvement (these changes were significant at P≤ 0.05 using the Wilcoxon matched pairs test) was in self-esteem (+45) and satisfactory relationships (+42)
- The comparison group, which received no counseling, showed some changes at 3 months which were not significant. Anxiety, habits and behavior scores increased

5.2.3 Schizophrenia

Borras L et al did a cross sectional study whereby the study examined how religious beliefs and practices impact upon medication and illness representations in chronic schizophrenia.[21 level III] One hundred and three stabilized patients were included in Geneva's outpatient public psychiatric facility in Switzerland. Interviews were conducted to investigate spiritual beliefs, religious beliefs, religious practices and religious coping. Medication adherence was assessed through questions to patients and to their psychiatrists and by a systematic blood drug monitoring. Results showed that:

- Thirty-two percent of patients were partially or totally nonadherent to oral medication. Fifty-eight percent of patients were Christians, 2% Jewish, 3% Muslim, 4% Buddhist, 14% belonged to various minority or syncretic religious movements, and 19% had no religious affiliation.
- Two thirds of the total sample considered spirituality as very important or even essential in everyday life.
- Fifty-seven percent of patients had a representation of their illness directly influenced by their spiritual beliefs (Positively in 31% and negatively in 26%). Religious representations of illness were prominent in nonadherent patients.
  - ✓ The study highlighted that more than half of the patients had representations of their illness and treatment directly influenced by their religious convictions, positively in 31% (test sent by God to put them on the right path, a gift from God or of God's plan)
  - ✓ and negatively in 26% (punishment of God, a demon, the devil, or possession)
- Thirty-one percent of nonadherent patients and 27% of partially adherent patients underlined an incompatibility or contradiction between their religion and taking medication, versus 8% of adherent patients.
- More than two thirds of patients reported regular private religious practices (prayer, meditation, reading religious material, worship, etc) and one third reported regular religious practices in the community (attending church services, prayer, meditation, worship, or reading religious material with others).
- Thirty-one percent of nonadherent patients underlined contradiction or incompatibility between their spiritual convictions and supportive psychotherapy, contrary to 10% of adherent and 9% of partially adherent patients

The authors suggested that the results about the importance of the religious dimension and its potential impact on treatment adherence should be considered in the clinical management of patients with schizophrenia.

5.2.4 Mental Disorder

King M et al conducted a study to examine associations between a spiritual or religious understanding of life and psychiatric symptoms and diagnoses.[22] level III The authors analyzed data collected from interviews with 7403 people who participated in the third National Psychiatric Morbidity Study in England. The third National Psychiatric Morbidity Study was conducted between October 2006 and December 2007 across England, using individual or groups of postcode sectors as sampling units. The results showed that:

- Of the participants 35% had a religious understanding of life, 19% were spiritual but not religious and 46% were neither religious nor spiritual
- Religious people (the actual practice of a faith, e.g. going to a temple, mosque, church or synagogue) were similar to those who were neither religious nor spiritual with regard to the prevalence of mental disorders, except that the former were less likely to have ever used drugs (odds ratio (OR) = 0.73, 95% CI; 0.60–0.88) or be a hazardous drinker (OR = 0.81, 95% CI; 0.69–0.96).
- Spiritual people (do not follow a religion but do have spiritual beliefs or experiences) were more likely than those who were neither religious nor spiritual to have ever used (OR = 1.24, 95% CI; 1.02–1.49) or be dependent on drugs (OR = 1.77, 95% CI; 1.20–2.61), and to have abnormal eating attitudes (OR = 1.46, 95% CI; 1.10–1.94), generalized anxiety disorder (OR = 1.50, 95% CI; 1.09–2.06), any phobia (OR = 1.72, 95% CI; 1.07–2.77) or any neurotic disorder (OR = 1.37, 95% CI; 1.12–1.68). They were also more likely to be taking psychotropic medication (OR = 1.40, 95% CI; 1.05–1.86).
- The authors mentioned that people who have a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder.

The authors concluded that there was increasing evidence that people who profess spiritual beliefs in the absence of a religious framework are more vulnerable to mental disorder. The nature of this association needs greater examination in qualitative and in prospective quantitative research.

5.3 COST / COST EFFECTIVENESS / COST IMPLICATIONS

There was no retrievable evidence on cost, cost effectiveness or cost implications of spiritual therapy for mental disorders

5.3 LIMITATIONS

This technology review has several limitations. The selection of studies was done by one reviewer. Although there was no restriction in language during the search but only English full text articles were included in this report. Most of the studies retrieved were observational studies with short duration.

6. CONCLUSION

The majority of the studies were of observational, cross-sectional design which did not allow drawing any definitive conclusions about the causal relationships of the variables. Most of the studies are limited by the nature of the population studied and short duration of study. However, a systematic review showed that Intercessory prayer (IP) may improve health outcomes by lowering severity scores of patients, Islamic-based psychotherapy and religious activities speeds recovery from anxiety and depression in Muslim patients. Most of the studies showed that involvement in religious activities, religious beliefs, spiritual beliefs and practices may promote mental and physical health such as lowering the scores in depression and anxiety. Most of the findings suggested potential benefit namely religious quality involvement was protective through personal and meditative aspects for depression anxiety and schizophrenia. However, the long term effects of spiritual therapy for mental health disorders could not be determined. Hence, there is a need for more research in this area to gauge the beneficial effect of spiritual therapy and religiosity (aspects of religious activity, dedication, and belief), spiritual beliefs and practices has on health outcomes as an adjunctive treatment in patients with mental disorders such as anxiety, depression, and schizophrenia.

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16. Ellison CG, and Flannelly KJ. Religious Involvement and Risk of Major Depression in a Prospective Nationwide Study of African American Adults. *J Nerv Ment Dis* 2009; 197: 568–573
17. Daaleman TP and Kaufman JS. Spirituality and Depressive Symptoms in Primary Care Outpatients. The Southern Medical Association, 2006: 0038-4348/0-2000/9900-1340
18. Koenig HG. Religion and Depression in Older Medical Inpatients. Am J Geriatr Psychiatry 2007; 15:282–291
19. Cruz M, Schulz R, Pincus HA et al. The Association of Public and Private Religious Involvement With Severity of Depression and Hopelessness in Older Adults Treated for Major Depression. Am J Geriatr Psychiatry 17:6, June 2009
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9. APPENDIX

9.1. Appendix 1: LITERATURE SEARCH STRATEGY

Ovid MEDLINE® In-process & other Non-Indexed citations and OvidMEDLINE® 1948 to present

1. Spiritu$ Therap$/px [Psychology]
2. Spiritu$ Therap$/mt, px [Methods, Psychology]
3. "Religio$ and Medicine"/ or "Religion and Psychology"/ or Religion/ or Spirituality/
4. Mental Healing/ or Faith Healing/ or Religion/
5. "Religion and Medicine"/
6. 1 or 2 or 3 or 4 or 5
7. mental disorder$.mp. or Mental Disorder$/
8. Depression/ or depression.mp.
9. Anxiety/ or Anxiety Disorder$/ or anxiety.mp.
10. Depressive Disorder/ or Sleep Disorder$/ or sleep disturbance.mp. or Stress Disorder$, Post-Traumatic/
11. Stress, psycho$ or psychiatr$ or mental stress.mp.
12. Schizophrenia/ or "Religion and Psychology"/ or shizophrenia.mp. or Psychotic Disorders/
13. substance abuse.mp. or Substance-Related Disorder$/
14. 7 or 8 or 9 or 10 or 11 or 12 or 13
15. 6 and 14
16. limit 15 to (abstracts and english language and full text and humans and yr="2000 - Current")

OTHER DATABASES

EBM Reviews - Cochrane Central Register of Controlled Trials	Same MeSH, keywords, limits used as per MEDLINE search
EBM Reviews - Cochrane database of systematic reviews	
EBM Reviews - Health Technology Assessment	
EMBASE	

PubMeD

((spiritu* [Title/Abstract] OR religio* [title/Abstract] OR spiritual therapy$ [Title/Abstract]) OR (under[All Fields] AND (psychol* OR psychiatr* OR "mental disorder* [All Fields]) AND ("mental disorder"[MeSH Terms] OR “depressive disorder” [All fields] OR " mental distress "[All Fields] OR "schizoprenia"[All Fields] OR "sleep disorder$"[All Fields] OR “substance abuse"[All Fields])))

9.2. Appendix 2

DESIGNATION OF LEVELS OF EVIDENCE

I Evidence obtained from at least one properly designed randomized controlled trial.

II-I Evidence obtained from well-designed controlled trials without randomization.

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one centre or research group.

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III Opinions or respected authorities, based on clinical experience; descriptive studies and case reports; or reports of expert committees.

SOURCE: US/CANADIAN PREVENTIVE SERVICES TASK FORCE (Harris S2001)

Appendix 3

Evidence Table: Efficacy / Effectiveness
Question: Is spiritual therapy effective for mental disorders.

Bibliographic citation	Study Type / Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
1. Townsend and Mulligan. Systematic Review of clinical trials examining the effects of religion on health.Southern Medical journal, 2002; Vol 95: no 12	Systematic review. Assessed the impact of religion on health outcomes.		All RCT's published from 1966 to 1999 and all non-RCT's published from 1996 to 1999 that assessed a relationship between religion and measurable health outcome were examined. Nine RCT's and 25 non-RCT's met the inclusion criteria.	Intercessort prayer , Islamic-based psychotherapy			Results: • Intercessort prayer (IP)may improve health outcomes in patients admitted to a coronary care unit but showed no effect on alcohol abuse o Christian prayer results in 10% better outcomes in intervention group o The IP group subsequently had a significantly lower severity score based on the hospital course after entry ($P < .01$). Multivariate analysis separated the groups on the basis of the outcome variables ($P < .0001$). • Islamic-based psychotherapy speeds recovery from anxiety and depression in muslims o 3 RCT's evaluated the effect of islam-based psychotherapy on religious malay muslims. Patients who fulfilled the criteria for anxiety or depression were given religious psychotherapy (advice, encouragement based on the Koran and Hadith) in addition to traditional psychotherapy. o The results revealed that spritual islamic-based psychotherapy (SIPT) had more efficacy than medication based on both scales ($P < 0.01$); however, it was not different from cognative behavariol therapy (CBT). SIPT was more effective on the modification of dysfunctional attitudes compared with CBT and medication ($P < 0.05$). • Non-RCT's indicate that religious activities appear to benefit blood pressure, immune function, depression and mortality	

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Bibliographic citation	Study Type / Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
2. Ellison CG, and Flannelly KJ. Religious Involvement and Risk of Major Depression in a Prospective Nationwide Study of African American Adults. *J Nerv Ment Dis* 2009; 197: 568–573)	Cross sectional	III	The data used here come from the National Survey of Black Americans (NSBA), a nationwide longitudinal survey of African American adults conducted by the Survey Research Center at the University of Michigan in 1979–1980, 1987–1988, 1988–1989, and 1992 (Jackson, 1991; Taylor et al., 1997). After adjustments of cases with missing values on key variables, the effective sample size was 607. Information on depression was collected via the NIMH Diagnostic Interview Schedule (Brown et al., 2000; Robins et al., 1981), which gauges the presence, severity, and duration of symptoms. Major depression during the past 12 months was measured as a dichotomous variable (case = 1, no case = 0), based on DSM-III Diagnostic criteria. To be classified as depressed, after responding affirmatively to a screening question, respondents must have had atleast 3 depressive symptoms and must also have met severity criteria	3 aspects of religious involvement, which were measured at T1: religious attendance, religious guidance, and social support from church members.			Findings are presented as odds ratios (OR). Bivariate Associations Between the Religious Variables (T1) and Major Depression (T2) were measured: • the odds of major depression were roughly 50% lower (OR = 0.49, *p* = 0.05) among persons who report “a great deal” of guidance from religion in their day-to-day lives, as compared with those persons who received less guidance from their religion. • The odds of T2 major depression were reduced by roughly half (OR = 0.47, *p* = 0.05) forAfrican Americans aged 55, as compared with younger participants, and by roughly half (OR = 0.47, *p* = 0.05) for respondents whose baseline family income fell in the top one-third of the distribution, as compared with their less affluent counterparts. • Logistic regression found that survey participants who reported receiving “a great deal” of guidance from religion in their day-to-day lives at Time 1 (1988 – 1989) were roughly half as likely (OR = 0.47, *p*= 0.01) to have major depression at Time 2 (1992), controlling for socio demographic and psychological factors, and major depression at baseline. The odds of major depression were also lower for persons with high self-esteem (OR= 0.41, *p*= 0.01) and those who reported having satisfying relationships with friends and family members (OR = 0.51, *p* = 0.05) at baseline. • No association was found between religious attendance or church support and major depression.	

Evidence Table: Efficacy / Effectiveness

Bibliographic citation	Study Type / Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
3. Daaleman TP and Kaufman JS. Spirituality and Depressive Symptoms in Primary Care Outpatients. The Southern Medical Association, 2006: 0038-4348/0-2000/9900-1340	Cross sectional. to examine the association of spirituality and symptoms of depression in primary care outpatients. A cross-sectional analysis was performed of a dataset using 509 primary care outpatients who participated in instrument validity study in the Kansas City (US) area. Patients were administered the Zung Depression Scale (ZDS) and the Spirituality Index of Well-Being (SIWB) in the waiting area before or after their appointment. Bivariate and multivariate analyses were performed to determine the relationship between the factors of interest and depressive symptoms.		Subjects were adult outpatients who presented for care at one of ten family practices in the greater Kansas City area. To achieve a 5% margin of error, a minimum of 384 subjects were required for enrollment in the parent validity study. The preliminary sample size was set to 512, based upon a 75% participation rate and was subsequently rounded up to 550 to standardize the number of subjects (n =55) per site. Subjects were eligible if they were 18 years of age or older, English speaking, had no discernable cognitive impairment as determined by study personnel, and were willing to participate in the study.	Spirituality			Results: • A total of 550 subjects were approached and 509 patients participated in the study. • A total of 15 patients (3%) of the sample population reported depressive symptoms based on summed Zung Depression Scale scores of 50 or greater. • In bivariate analyses, less insurance coverage ($P < 0.01$) and greater spirituality ($P < 0.01$) were associated with less reported depressive symptoms. • In a model adjusted for covariates, spirituality ($P < 0.01$) remained independently associated with less depressive symptoms OR= 0.85 (95% CI; 0.80, 0.91) Primary care outpatients who report greater spirituality are more likely to report less depressive symptoms.	

Question: Is spiritual therapy effective for mental disorders.

Evidence Table: Efficacy / Effectiveness
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Bibliographic citation	Study Type/ Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
4. Koenig HG. Religion and Depression in Older Medical Inpatients. Am J Geriatr Psychiatry 2007; 15:282–291	Cross sectional study. purpose of this study was to examine the impact of patient characteristics on the course of depression in patients hospitalized with congestive heart failure and chronic pulmonary disease (CHF and/or CPD)	III	Between 1999 and 2003, research nurses assessed consecutive medical inpatients with CHF/ CPD over age 50 admitted to *Duke University Medical Center, Durham (*DUMC) or three nearby smaller community hospitals. Patients were screened for depressive disorder using the Structured Clinical Interview for *DSM–IV* (SCID-I/NP, version 2.0). Data were collected only on patients identified with depressive disorder. Severity of depression was determined using the 17-item Hamilton Depression Rating Scale (HDRS) (range: 0–52). Severity of CHF/CPD was assessed using the dyspnea subscale of the Chronic Heart Failure/ Chronic Pulmonary Disease Questionnaire	Religious characteristics examined were religious affiliation, spiritual–religious self-categorizations, public and private religious activities, and intrinsic religiosity. Religious affiliation was grouped into seven categories: 1) Protestant unspecified, 2) Reformation Protestant (i.e., Presbyterian, Lutheran, Episcopalian), 3) Pietistic Protestant (i.e., Methodist, Baptist, Christian), 4) Neofundamentalist Protestant (i.e., Church of God, Pentecostal Holiness, Southern Baptist), 5) Catholic, 6) nontraditional Christian and other religions (Jehovah Witnesses, Jewish, Muslim, and so on), and 7) no affiliation. Patients were then asked to categorize themselves as 1) spiritual but not religious, 2) religious but not spiritual, 3) both religious and spiritual, and 4) neither religious nor spiritual ("spiritual" and "religious" left to the patient to define).			One thousand patients with CHF only (N=174), CPD only (N=527), or both (N=299) were identified with depressive disorder, 505 at DUMC and 495 at community hospitals. Of these, 59% had minor depression and 41% had major depression. Both disorders required current impairment of psychological, social, or occupational functioning. • Patients with no religious affiliation were 12.7 and 10.3 times more likely to have major and minor depression, respectively, than patients with an affiliation. • Neofundamentalists, however, were 84% and 83% less likely to have major and minor depression, respectively. • Patients who considered themselves spiritual but not religious were 4.5 and 3.7 times more likely to have major and minor depression, respectively. • Those who indicated they were both spiritual and religiouswere approximately 80% less likely to have depressive disorder. • There was no relationship between depression and religious attendance or other group religious activity. • Patients who prayed at least once a day were only half as likely to experience major and minor depression (48% and 54%, respectively). • Patients who watched religious TV or listened to religious radio at least several times per week were 35% less likely to have minor depression. • Patients who scored higher on intrinsic religiosity were less likely to have major depression (3% reduction for every one-point higher) and especially less likely to have minor depression (4% reduction for every one-point higher). • After controlling for demographic and physical health factors, depressed patients were more likely to indicate no religious affiliation, less likely to affiliate with neofundamentalist denominations, more likely to indicate "spiritual but not religious," less likely to pray or read scripture, and scored lower on intrinsic religiosity. Among depressed patients, there was no relationship between religion and depression type, but depression severity was associated with a lower religious attendance, prayer, scripture reading, and lower intrinsic religiosity. Social factors only partially explained these relationships. Older medically ill hospitalized patients with depression are less religiously involved than nondepressed patients or those with less severe depression.	

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Question: Is spiritual therapy effective for mental disorders.

Bibliographic citation	Study Type / Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
5. Cruz M, Schulz R, Pincus HA et al. The Association of Public and Private Religious Involvement With Severity of Depression and Hopelessness in Older Adults Treated for Major Depression. Am J Geriatr Psychiatry 17:6, June 2009	Cross sectional study: The authors assessed the association between public and private religious participation and depression as well as hopelessness in older depressed, adults treated in mental health settings.	III	Data from 130 participants from a posttreatment longitudinal follow-up study of late-life depression were analyzed. Treatment study participants were recruited from the geriatric inpatient units and outpatient clinics at the Western Psychiatric Institute and Clinic, Pittsburgh Multiple regression analyses were performed to assess the association between public (frequency of church attendance) and private (frequency of prayer/meditation) forms of religious participation and depression as well as hopelessness severity when demographic and health indicators were controlled.	frequency of church attendance, (frequency of prayer/meditation, forms of religious participation			Results: • Twenty-nine participants scored 9 or above on the Beck Hopelessness Scale (BHS)and 41 participants' scored 7 or less on the post treatment Hamilton Rating Scale for Depression(HRSD) • 92% of participants reported a religious affiliation with 60% of participants reporting attending church at least once a week (mode = 5) and 84% reporting privately praying or meditating at least every day (mode = 6). • Multivariate analyses found significant negative associations between frequency of prayer /meditation and depression (OR = 0.56 [0.36–0.89], as well as hopelessness severity (OR = 0.58 [0.36–0.94]. • male gender was significantly associated with hopelessness (OR = 2.79 [1.03–7.48], • prayer was significantly associated with less hopelessness (OR = 0.58 [0.36–0.94 and reduced depression severity scores (OR= 0.56 [0.36–0.89], • Church attendance was not significantly associated with depression (OR= 0.914 [0.70 – 1.189], or hopelessness (OR= 0.78 [0.58– 1.04] • Hence, frequency of prayer or meditation but not church attendance predicted lower hopelessness and depression severity scores in older adults treated for depression in mental health settings This study supports significant, direct relationships between prayer/meditation and depression as well as hopelessness severity in older adults treated for depression in mental health settings. Prospective studies are needed to further illuminate these relationships.	

Evidence Table: Efficacy / Effectiveness
Question: Is spiritual therapy effective for mental disorders.

Bibliographic citation	Study Type / Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
6. Hurst GA, Williams MG, Judith E. King JE et al. Faith-Based Intervention in Depression,Anxiety, and Other Mental Disturbances; 2008 by The Southern Medical Association 0038-4348/0-2000/10100-0388	Cross sectional study. A 12-item questionnaire was completed before the appointment. At the conclusion of the Steps to Freedom session the client was given a post-appointment questionnaire and a self-addressed stamped envelope and asked to return the questionnaire in 7 days. Another post-appointment questionnaire with a self-addressed stamped envelope was mailed 3 to 4 months later to each client. In Texas, each client and comparison (control) member was also given the SCL-90-R questionnaire along with the 12-item questionnaire. The lengthy SCL-90-R questionnaire has been subjected to extensive research, and has demonstrated scientifically acceptable validity and reliability.	III	This study used a new 12-item Likert scale questionnaire designed to test whether a faith-based intervention would have a positive effect in individuals with a variety of emotional/ mental and behavioral difficulties. The outcome study was carried out on 33 individuals who attended a Living Free in Christ Conference in Edmond, OK, or in Tyler, TX. The selection was made on the basis of the following priorities: (1) presence of significant depression including suicidal tendencies, anxiety, and other typical presenting problems; (2) Availability of the client during the 3 days following the conference.	Each Step to Freedom appointment uses prayers to ask forgiveness and have faith in God to enable clients to address and resolve past and present personal and spiritual problems. Steps to Freedom appointments were offered free of charge and lasted approximately 6 or 7 hours. In discipleship counseling literature, the lay counselors are referred to as encouragers and clients are referred to as counselees.	A comparison "control" group consisted of 40 volunteers who attended the Tyler, TX, host church on the Sunday after the conclusion of the conference. These individuals had not attended the conference and had never gone through the Steps to Freedom.		Data from 33 clients at 3 to 4 months were as below: • The post counseling percentage decrease (improvement), in symptom/behavior was: -49% for depression, -44% for anxiety, _49% for fear (irrational),-45% for anger (unhealthy), -42% for tormenting thoughts and voices, and -46% for habits and behavior. All the changes were statistically significant for all categories at $P \leq 0.005$. Statistically • Significant changes $P \leq 0.05$ (improvement) occurred in all six of the function areas. The greatest percent improvement was in self-esteem (+45) and satisfactory relationships (+42). • The comparison group, which received no counseling, showed some changes at 3 months which were not significant. Anxiety, habits and behavior scores increased.	

Evidence Table: Efficacy / Effectiveness
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Bibliographic citation	Study Type / Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
7. Borras L, Mohr S, Brandt PY et al. Religious Beliefs in Schizophrenia: Their Relevance for Adherence to Treatment. Schizophrenia Bulletin vol. 33 no. 5 pp. 1238–1246, 2007. Doi:10.1093 /schbul/sbl070	cross sectional: The study examined how religious beliefs and practices impact upon medication and illness representatio ns in chronic schizophrenia	III	One hundred three stabilized patients were included in Geneva's outpatient public psychiatric facility in Switzerland. Interviews were conducted to investigate spiritual and religious beliefs and religious practices and religious coping. Medication adherence was assessed through questions to patients and to their psychiatrists and by a systematic blood drug monitoring.	Spiritual and religious beliefs and religious practices and religious coping.			Results: • Thirty-two percent of patients were partially or totally nonadherent to oral medication. Fifty-eight percent of patients were Christians, 2% Jewish, 3% Muslim, 4% Buddhist, 14% belonged to various minority or syncretic religious movements, and 19% had no religious affiliation. • Two thirds of the total sample considered spirituality as very important or even essential in everyday life. • Fifty-seven percent of patients had a representation of their illness directly influenced by their spiritual beliefs (Positively in 31% and negatively in 26%). Religious representations of illness were prominent in nonadherent patients. ✓ The study highlighted that more than half of the patients had representations of their illness and treatment directly influenced by their religious convictions, positively in 31% (test sent by God to put them on the right path, a gift from God or of God's plan) ✓ and negatively in 26% (punishment of God, a demon, the devil, or possession) • Thirty-one percent of nonadherent patients and 27% of partially adherent patients underlined an incompatibility or contradiction between their religion and taking medication, versus 8% of adherent patients. • More than two thirds of patients reported regular private religious practices (prayer, meditation, reading religious material, worship, etc) and one third reported regular religious practices in the community (attending church services, prayer, meditation, worship, or reading religious material with others). • Thirty-one percent of nonadherent patients underlined contradiction or incompatibility between their spiritual convictions and supportive psychotherapy, contrary to 10% of adherent and 9% of partially adherent patients The authors suggested that the results about the importance of the religious dimension and its potential impact on treatment adherence should be considered in the clinical management of patients with schizophrenia.	

Evidence Table: Efficacy / Effectiveness
Question: Is spiritual therapy effective for mental disorders.

Bibliographic citation	Study Type / Method	LE	Number of patients and characteristics	Intervention	Comparison	Length of follow up	Outcome measures/ Effect size	comment
8. King M, Marston L, McManus S et al. Religion, spirituality and mental health: results from a national study of English households The British Journal of Psychiatry 1–6. doi: 10.1192/bjp.bp.112.112003	Cross sectional study to examine associations between a spiritual or religious understanding of life and psychiatric symptoms and diagnoses.	III	The third National Psychiatric Morbidity Study was conducted between October 2006 and December 2007 across England, using individual or groups of postcode sectors as sampling units. The authors analyzed data collected from interviews with 7403 people who participated in the third National Psychiatric Morbidity Study in England.	religious and spiritual beliefs, actual practice of a faith, e.g. going to a temple, mosque, church or synagogue.			Results: • Of the participants 35% had a religious understanding of life, 19% were spiritual but not religious and 46% were neither religious nor spiritual. • Religious people were similar to those who were neither religious nor spiritual with regard to the prevalence of mental disorders, except that the former were less likely to have ever used drugs (odds ratio (OR) = 0.73, 95% CI 0.60–0.88) or be a hazardous drinker (OR = 0.81, 95% CI 0.69–0.96). • Spiritual people were more likely than those who were neither religious nor spiritual to have ever used (OR = 1.24, 95% CI 1.02–1.49) or be dependent on drugs (OR = 1.77, 95% CI 1.20–2.61), and to have abnormal eating attitudes (OR = 1.46, 95% CI 1.10–1.94), generalized anxiety disorder (OR = 1.50, 95% CI 1.09–2.06), any phobia (OR = 1.72, 95% CI 1.07–2.77) or any neurotic disorder (OR = 1.37, 95% CI 1.12–1.68). They were also more likely to be taking psychotropic medication (OR = 1.40, 95% CI 1.05–1.86). • The authors mentioned that people who have a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder. The authors concluded that there is increasing evidence that people who profess spiritual beliefs in the absence of a religious framework are more vulnerable to mental disorder. The nature of this association needs greater examination in qualitative and in prospective quantitative research.	