THE RELIGIOUS EXPERIENCE

OF

PEOPLE WITH ENDURING MENTAL HEALTH PROBLEMS

DIANA MAEVE FELLOWES ©

Thesis submitted for the Degree of Doctor of Philosophy

Department of Sociology
University of Surrey
Guildford

February 2005
This thesis is dedicated to the two most precious people in my life, my husband Robert, and daughter Celia.

Their love and encouragement never wavered.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>v</td>
</tr>
<tr>
<td>Abstract</td>
<td>vi</td>
</tr>
<tr>
<td><strong>Chapter 1 ‘In the Beginning’</strong></td>
<td>1</td>
</tr>
<tr>
<td>Outline of the Thesis</td>
<td>8</td>
</tr>
<tr>
<td><strong>Chapter 2 The Interface between Mental Illness and Religion</strong></td>
<td>10</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>10</td>
</tr>
<tr>
<td>2.2 Historical Beliefs about Mental Illness</td>
<td>11</td>
</tr>
<tr>
<td>2.3 Care of the Mentally III in England</td>
<td>13</td>
</tr>
<tr>
<td>2.4 Religious Care of the Mentally III in England</td>
<td>19</td>
</tr>
<tr>
<td>2.5 Sociological Perspectives of Mental Illness</td>
<td>22</td>
</tr>
<tr>
<td>2.6 Concept of Mental Illness</td>
<td>28</td>
</tr>
<tr>
<td>2.7 Concept of Religion</td>
<td>31</td>
</tr>
<tr>
<td>2.7.1 Substantive Definitions</td>
<td>32</td>
</tr>
<tr>
<td>2.7.2 Functional Definitions</td>
<td>35</td>
</tr>
<tr>
<td>2.8 Religious Experience</td>
<td>37</td>
</tr>
<tr>
<td>2.9 Conclusions</td>
<td>41</td>
</tr>
<tr>
<td><strong>Chapter 3 The Religious Experience of the Mentally Ill: Previous Research</strong></td>
<td>44</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>44</td>
</tr>
<tr>
<td>3.2 Relationship between Religion and Psychiatry</td>
<td>44</td>
</tr>
<tr>
<td>3.3 Religious Experience</td>
<td>52</td>
</tr>
<tr>
<td>3.4 Conclusions</td>
<td>56</td>
</tr>
<tr>
<td><strong>Chapter 4 The Research Process</strong></td>
<td>57</td>
</tr>
<tr>
<td>4.1 Introduction</td>
<td>57</td>
</tr>
<tr>
<td>4.1.1 Background History of the Research Population</td>
<td>58</td>
</tr>
<tr>
<td>4.1.2 Size and Profile of the Research Population</td>
<td>60</td>
</tr>
<tr>
<td>4.2 Negotiating Access</td>
<td>60</td>
</tr>
<tr>
<td>4.2.1 Vulnerable People</td>
<td>62</td>
</tr>
<tr>
<td>4.2.2 Informed Consent</td>
<td>64</td>
</tr>
<tr>
<td>4.2.3 Institutional Constraints</td>
<td>66</td>
</tr>
<tr>
<td>4.3 Stage 1 Research Design</td>
<td>68</td>
</tr>
<tr>
<td>4.3.1 The Sample</td>
<td>69</td>
</tr>
<tr>
<td>4.3.2 Questionnaire Construction</td>
<td>70</td>
</tr>
<tr>
<td>4.3.3 The Stage 1 Interview Schedule</td>
<td>72</td>
</tr>
<tr>
<td>4.3.4 Pre- Pilot Study</td>
<td>77</td>
</tr>
<tr>
<td>4.3.5 Pilot Study</td>
<td>77</td>
</tr>
<tr>
<td>4.3.6 Preparation</td>
<td>78</td>
</tr>
<tr>
<td>4.3.7 Reaction to the Stage 1 Interviews</td>
<td>79</td>
</tr>
<tr>
<td>4.4 Stage 2 Interviews</td>
<td>80</td>
</tr>
</tbody>
</table>
Chapter 5  Religiosity of Mentally Ill People: An Overview

5.1 Introduction 84
5.2 Characteristics of the Sample – Demographics 84
  5.2.1 Gender and Age 84
  5.2.2 Social Class and Occupation 86
  5.2.3 Education 94
5.3 Social Resources 97
  5.3.1 Accommodation 97
  5.3.2 ‘Do you know your neighbours?’ 98
  5.3.3 Belonging to clubs 99
  5.3.4 Free time 102
  5.3.5 Summary 103
5.4 Religion in the Lives of the Respondents 103
  5.4.1 Religious Experience 104
  5.4.2 Measuring Religious Identification 106
  5.4.3 Religious Practice 108
  5.4.4 Beliefs 112
  5.4.5 Superstitions 116
  5.4.6 Religious Needs and Resources 117
  5.4.7 Prayer 118
  5.4.8 Relationship to Congregations 118
  5.4.9 Summary 123
5.5 Discussion of Spiritual Issues with Professions 123
5.6 Conclusions 125

Chapter 6  Religious Experience

6.1 Introduction 128
6.2 Overview of My Sample’s Religious Experiences 129
6.3 Analysing the Religious Experiences 130
  6.3.1 ‘Presence of the Supernatural’ (i) God: 133
  6.3.1 ‘Presence of the Supernatural’ (ii) Other Supernatural 138
  6.3.2 ‘Prayer’ 141
  6.3.3 ‘Christian Experiences’ (i) Conversion 144
  6.3.3 ‘Christian Experiences’ (ii) Baptism of the Holy Spirit 150
  6.3.3 ‘Christian Experiences’ (iii) Baptism 151
  6.3.4 ‘Physical Sensations’ (i) ‘High’ 152
  6.3.4 ‘Physical Sensations’ (ii) Smell 153
  6.3.4 ‘Physical Sensations’ (iii) Hear 154
  6.3.4 ‘Physical Sensations’ (iv) Heat 155
  6.3.4 ‘Physical Sensations’ (v) See 156
  6.3.4 ‘Physical Sensations’ (vi) Feelings of: peace; calm; and “nice” 158
  6.3.4 ‘Physical Sensations’ (vii) Hallucinations 159
6.3.5 ‘Extraordinary Experiences’  
6.3.5 ‘Extraordinary Experiences’ (i) Out of Body  
6.3.5 ‘Extraordinary Experiences’ (ii) Near Death  
6.3.5 ‘Extraordinary Experiences’ (iii) Healing  
6.3.5 ‘Extraordinary Experiences’ (iv) Warning  
6.3.5 ‘Extraordinary Experiences’ (v) Déjà Vu/Premonitions  
6.3.6 ‘Reflexive Experiences’  
6.3.7 ‘Would Not Relate Experience’  
6.4 Discussion  

Chapter 7 Light in the Darkness? Religious Beliefs and Practices  
7.1 Introduction  
7.2 Beliefs - Spiritual Warfare  
7.3 The Devil  
7.4 God  
7.5 Experiences of Church Attendance  
7.6 Prayer  
7.7 Conclusions  

Chapter 8 Talking and Telling  
8.1 Introduction  
8.2 Customary and Extraordinary Communication  
8.3 Fears of Religious Ideation Being Pathologised  
8.4 Religious Ideology: A Private Matter  
8.5 Confident Religious Service Users  
8.6 Conclusion: The Search for a ‘Protective Cocoon’  

Chapter 9 Journey’s End  
9.1 Introduction  
9.2 Service Users  
9.3 Researching Service Users  
9.4 Religious Experience of Service Users  
9.5 Ontological Security  
9.6 Implications Drawn from the Research  

REFERENCES  

Appendix One Information Sheet for Initial Interview  
Appendix Two Consent Form for Initial Interview  
Appendix Three Interview Schedule  
Appendix Four Information Sheet for Second Recorded Interview  
Appendix Five Consent Form for Second Recorded Interview  
Appendix Six Profile of Respondents Who Had a Religious Experience
List of Tables

Table 5.1  Number of respondents by age groups and gender  86
Table 5.2  Current employment, service users compared to general population  90
Table 5.3  Present/last occupation by age  91
Table 5.4  Present/last occupation by religious status  91
Table 5.5  Present/last occupation by past and present church attendance  92
Table 5.6  Professionals’ church attendance and beliefs  93
Table 5.7  ‘Unskilled-manuals’ church attendance and beliefs  93
Table 5.8  Non-church attenders: comparison of ‘middle’ and ‘working’ class religious beliefs  94
Table 5.9  Terminal Education Age, research sample compared with the WVS 1990  95
Table 5.10  Effect of education on religious beliefs and practice  96
Table 5.11  Accommodation by gender and age  98
Table 5.12  Membership of clubs, comparing sample of service users with general population WVS 1990  101
Table 5.13  Membership of clubs by age and gender  101
Table 5.14  Use of free time by age and gender  103
Table 5.15  Religious status by age and gender  107
Table 5.16  Religious status, research sample compared with the WVS 1990  108
Table 5.17  Religious practice by gender  109
Table 5.18  Religious practice by age  109
Table 5.19  Frequency of religious practice by gender  110
Table 5.20  Attendance at religious services, comparing service users with WVS 1990  110
Table 5.21  Religious denomination of those who attended a religious services, compared to general population  111
Table 5.22  Age of service users attending services by denomination  112
Table 5.23  The importance of God in service user’ lives, compared to World Value Survey 1990  113
Table 5.24  Personal Statement of Belief  114
Table 5.25  Percentages within age groups of personal beliefs  114
Table 5.26  Service users’ beliefs, compared to British General Population  115
Table 5.27  Belief in the Devil by gender and age  116
Table 5.28  Frequency of prayer by service users/ percentage within gender  118
Table 5.29  Know people within the congregation by denomination and attendance  119
Table 5.30  People known personally in the congregation, English compared to US samples  119
Table 5.31  Meaning and purpose of life, compared to general population of GB  121
Table 5.32  Religious Needs – comparison of English and Us patients  122
Acknowledgements

This thesis would not have been completed without the help, encouragement, and interest of many people, and to each one I owe a debt of gratitude.

I am especially grateful to my two supervisors Professor Mike Hornsby-Smith and Jo Moran-Ellis who succeeded in refocusing my vision from that of a clinician looking at individuals to observing the world through the eyes of a sociologist. No student could ask more of supervisors as they complemented each other perfectly and provided constant guidance, advice and support. Thanks are also due to many other members of staff in the Department of Sociology at Surrey University, especially Agnes McGill.

As has been noted gaining access to my sample was arduous, and therefore I am most grateful for all the help given by the Psychiatric Service staff to enable the research to take place. However, special thanks are due to fellow occupational therapist Sue Haspel who encouraged some of the most fragile service users in her care to talk to me, without which the data would not have been so rich. I would also like to thank each one of the respondents who shared with me very personal details of their religious lives, and hope that I have portrayed their narratives accurately.

Finally, I would like to thank my husband Robert and daughter Celia for all their love and support during the long research process.
Abstract

This thesis expands the knowledge base regarding a group of people who are under researched and whose religious experiences, interests and beliefs have hitherto not been investigated. It examines the religious experience of a sample of people with enduring (chronic) mental health problems living in the South East of England. The few studies that consider religious variables in the mentally ill lack conceptual and methodological sophistication, and the scant religious data that have been gathered in the UK and the US primarily record either religion or denominational affiliation. However, several authors argue that there is a 'religiosity gap' between the users and providers of mental health services.

This research entailed a structured interview with one hundred users of a Psychiatric Service to investigate their religious lives, and to identify those who had had a 'religious experience'. Thirty-six of the sixty-seven respondents who had such an experience were then interviewed in depth to explore the function that religion served in their lives, and to understand how it interfaced with their psychopathology.

Sociologically the beginning of a new millennium is an interesting time to study and reflect upon the interface between two social phenomena that have undergone significant changes during the latter years of the last century: mental illness and religion. The mentally ill are no longer institutionalised and secluded from society but have become individuals with rights living in the community, who can contribute to the understanding of their own mental health. Altered too is the place of religion in society and in the lives of individuals, and England has changed from being a Christian country, albeit nominally, to proclaiming its multicultural nature, with patterns of church attendance dramatically reduced.

However, a high proportion of the mentally ill still look to religion and I was concerned to understand from a sociological perspective the factors that accounted for this. This thesis argues that the religious beliefs and practices of those with enduring mental health problems do not differ fundamentally from those of the general population, although they are more likely to believe in the more frightening aspects of Christianity – the Devil and hell.

This finding fits into the main argument of the thesis that for those people with enduring mental health problems for whom religion and religious experiences are important, religion can provide a framework that enables them to make sense of the turbulent, and often frightening, thought processes arising on a recurrent basis from their illnesses. Religion can provide order amidst the chaos that severe mental illness can bring, thus helping to restore their ontological security.
Chapter 1

‘In the Beginning’

The dimension that religion plays in the lives of psychiatric patients was drawn to my attention following an incidence that occurred early in my training as an occupational therapist. As an eighteen-year-old student I had worked in two large mental hospitals that were built as Victorian lunatic asylums, and on some long-term locked wards it was easy to imagine that little had changed in ninety years. A vivid memory, which could have come from a Hogarth painting, was a visit one Sunday to the Morning Service in the hospital church. As a child I had experienced the solemn formality of both English Protestant and Roman Catholic church services, and the exuberance of Non-Conformist worship in the American Deep South, but nothing had prepared me for ‘religion’ in a mental institution. There was one priest taking the service, but the cacophony of sounds emanating from most of the patients in the congregation as they interacted with their ‘voices’ and ‘paranoid delusions’ almost drowned him out. Whether they had attended voluntarily, or whether the staff had decided to take them to church through good intentions or for want of any other form of distraction, I never knew.

The interface between mental illness and religion aroused my interest further following research into the impact on the local community when the Victorian mental hospital in which I worked closed, and all the psychiatric patients were resettled into a small English commercial town (Fellowes 1996). The research looked at how groups of non-medically trained people working in the locality were affected when the large number of psychiatric patients were discharged, and became their clientele. Of the groups investigated (shops, financial institutions, transport providers, police and churches) the police and clergy were the only ones who noticed an increase in their workload due to the hospital’s closure. I could understand that the police would be affected by the presence of more patients in the community: as with any citizen, if a patient caused a disturbance the police were summoned, and when a dangerous patient was committed to hospital under a section of the Mental Health Act the police were frequently called to provide secure transportation. What surprised me was that in an era of secularisation the ex-hospital residents were seeking the solace of the church, or if not the church the priest in charge of the church.
From my experience of working with the psychiatric patients in the hospital before it closed I knew of only a few who had gone to the church in the hospital grounds, and when working in the local community only a small number of patients acknowledged religious interests. From my observation of the patients who professed to be Christians few attended a church. It was not part of the medical assessment to enquire into the patients’ religious interest or needs, apart from the sterile question ‘Religion?’ included in the biographical details on all case notes, to which the reply was often simply a non-committal ‘C of E’. Religious interests would only become apparent if patients spoke about them, or it was part of their psychopathology and had a negative impact on their mental health. Had patients quietly gone to the local clergy to seek help and kept it compartmentalised from the medical staff? Should the medical staff consider the religious interests of their patients in relation to the care they offered them? Where did religion fit into the ‘holistic approach’ that is now advocated by increasing numbers of medical and lay people?

The Mental Health Foundation published a report *Knowing our own Minds* (McKerrow and Faulkner 1997) in which people with a range of mental health problems reported activities, treatments and therapies that they found helpful, and explored different coping strategies they had developed to deal with their difficulties. They looked at medication, ECT, talking therapies, alternative remedies, and leisure activities. What was of interest to me was their incorporation of religious and spiritual beliefs in their survey. As Peter Campbell, a user of mental health services for thirty years, wrote in the foreword:

...it is good to see the inclusion of spirituality within the survey – an area of human concern largely overlooked by most health experts. I have only ever met one psychiatric professional who expressed any interest in my spiritual life. Yet the dictionary I use still defines ‘psyche’ as soul and spirit as well as mind. (McKerrow and Faulkner 1997: Forward)

Of the 401 mentally ill people who completed the questionnaire to express their views, religious or spiritual beliefs played a part in the lives of over 50%. Having worked with mentally ill people for so many years, I was aware that this level of interest in spiritual matters had never been recognised or acknowledged. Was this the fault of the mental health professionals working within a biochemical model or did the patients choose to keep their spiritual and medical personas separate? If the latter were the case, was that because the medical professionals set unspoken boundaries as they felt insecure dealing with matters outside their model? Did they discourage patients from admitting to
spiritual interests by pathologising something felt very deeply by the patients? Had the patients felt that the professionals were biased against religious matters, or had they experienced having their religious concerns labelled as part of their mental illness or delusional system?

Marcia Murphy, a sufferer from schizophrenia, in describing the difficulty she had experienced with doctors said:

> Doctors may think psychoses are the result of physiological disorder, because science and religion have long been considered immiscible. So, if someone in the field of psychology or psychiatry does not believe in God or spirituality, his or her interpretation of what happens to a person may leave out the possibility that God played a part in or through that person’s psychotic experience. (Murphy 1997:543)

Lukoff (1992) acknowledged that religious and spiritual dimensions were fundamental to human experience, yet he found that mental health professionals tended to ignore or pathologise this dimension of their patients’ lives. He called for a more ‘culturally sensitive’ form of psychiatric classification so that psychosocial and cultural factors would be taken into account when diagnosing mental illness. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-111-R) which was used by psychiatrists to diagnose mental illness, religion was consistently portrayed negatively. All twelve references to religion in the Glossary of Technical Terms were used to illustrate psychopathology (mental illness). Lukoff felt that there was a ‘religiosity gap’ between the medical staff and patients, due mainly to the clinicians’ lack of training in religious matters and their use of the biochemical model which ignored the possibility of a non-biological cause of experiences, or even of the independence of religious concerns.

Murphy (1997) spoke from her knowledge as a patient and found that she viewed her religious experiences in a totally different way to the atheist psychiatrists and therapists. They saw her psychotic phenomena in a purely negative way that needed treatment, whereas she felt that the religious components of her experiences had a beneficial effect on her mental state which had transformed her life.

Certainly, it appeared to me that patients were neither encouraged, nor volunteered, to speak about the spiritual dimension of their lives to the medical staff. These professionals wielded great power over patients’ lives and could commit a person to

---

1 Current at the time when Lukoff wrote this article. It was replaced by the DSM-IV in 1994.
hospital if they considered their mental state to be of danger to themselves or others. If, indeed, any expressed religious experience might be liable to lead to a diagnosis of mental illness it was understandable that patients who were aware of this, or believed it to be the case, might be reluctant to disclose religious or spiritual ideation. I wondered if the power balance was so weighted against patients that they feared to express views that might be considered unstable, which could lead to being detained compulsorily under the Mental Health Act and committed unwillingly to hospital. A patient once confided in me that she did not tell the staff that she visited the hospital chapel daily for fear that they would think her too ill to be discharged home. Alternatively, do patients consider their spiritual lives to be no part of the healing process offered by the medical staff, and prefer not to reveal this side of their nature?

There were many issues that I wanted to research to take further the work of McKerrow and Faulkner (1997). I sought to investigate the religious aspect of a group of people with mental health problems who would be similar to those surveyed by the Mental Health Foundation, in that they suffered from enduring (chronic) mental health problems, but who would be more representative of mentally ill people generally. The sample in McKerrow and Faulkner’s survey was entirely self-selected, having been invited to take part in the survey by advertising in newspapers and in newsletters of organisations interested in mental health. They particularly wanted to target black and ethnic groups, so distributed the questionnaires to projects, mental health service user groups and networks working with these mentally ill people. They were aware that their method would over-represent those interested in alternative or complementary medicine and those from ethnic minorities. I felt that their method might only include those mental health sufferers who would respond to advertisements for people wanting to express their views, and who would be able to fill in a written questionnaire. I considered that only taking the views of outgoing and literate people might not give a true picture of the level of religious interest in a wider range of psychiatric patients. It was also possible that people who were interested in alternative therapies might be more religious than the general population of mentally ill people.

I wanted a sample that would cover a wide range of variables: age; gender; ethnicity; marital status; accommodation; educational attainment; employment and class. I decided therefore to examine the group of patients that I had been working with as an occupational therapist for the past seven years who were being treated in one Psychiatric Service. From my experience as a member of staff within the service, I was
aware that the racial mix was predominantly white Caucasian which would reflect the
catchment area of the Psychiatric Service while not the whole country, particularly
some inner city areas. However, I felt that it would be more representative of the
population of psychiatric patients than the Mental Health Foundation’s survey which
targeted the ethnic minorities.

At the time that I was writing up my research there was emerging in the mental health
literature a change in the language used to describe people who suffer with mental
health problems: instead of being referred to as ‘patients’ they were called ‘service
users’ or ‘survivors of the mental health system’. As Wykes (2003:2) argued, when
looking at the new emphasis on service user involvement in research, “The use of
language frames the way in which we think about the world”. Interestingly the term
‘patient’ had replaced the description ‘inmate’ in the old Psychiatric Hospital in 1935
(Welch 1993:8). The change of terminology therefore pointed to a paradigm shift in the
power balance between the medical professionals and the people they treated. The
‘patients’ had become ‘users’ of the mental health service rather than passive recipients
of treatment, and as such were theoretically becoming empowered as ‘partners’ and
’statgeholders’ (DOH 2001) within the system. However, Foskett (2004a:2) was keen to
point out that this rethinking was not “about bashing psychiatrists”:

It would be easy to misunderstand this movement as one akin to the anti­
psychiatry protests of the 60s and 70s...This user/survivor movement is
about creating a balance between what individuals can contribute to their
own care and cure and what others – professionals, families, friends and
society as a whole can contribute too. (Foskett 2004a:2)

This paradigm shift fitted well into the philosophical underpinning of my research, as I
had wished to redirect the balance of power by listening to and taking note of the
service users and not the medical professionals. Clearly what had been an innovative
approach when I commenced the research was slowly being recognised as good
practice.

The change in emphasis and rebalancing of power seemed a very positive change,
provided that the motivation behind the succession of government policy initiatives and
guidance documents was actually realised, and did not simply apply a new label to a
group of vulnerable people. Listening to service users was foundational to a new
‘partnership’ between those suffering from a mental illness and those caring for them.
The new emphasis on listening to service users added emphasis to the focus of my own
research.
An issue that aided my research and encouraged the service users to speak to me was my status as an 'insider' of the Psychiatric Service, and the fact that many of the service users knew me. As religion could be a sensitive issue which they might not discuss with a stranger, I was enabled to broach this topic with this vulnerable group because they, and their gatekeepers, trusted me. However, there appear now to be three genres of research in this field: that undertaken by 'outsiders', such as medical professionals and academics, which Townsend and Braithwaite (2002:117) reject; research by 'insider' service users, which they would advocate; and research that I undertook as an 'insider/outsider'. The position that I held with the status of an insider/outsider gave my research a different perspective to any other: I was an 'insider' as one who was well known and trusted by many of the respondents and staff, but an 'outsider' in that I was not a service user. This position for my purpose was ideal, because I had access to the sample, and also clarity of vision because I was neither service user nor staff with the vested interests that each held.

This research that sought to listen to the voices of service users would be in two parts. Stage 1 would be quantitative, when one hundred service users attending the Psychiatric Service would be interviewed in order to fill in an interview schedule to gain an overview of their religious interests, needs and practices, and to ascertain how many considered that they had had a religious experience. The data would be entered into an SPSS database and analysed.

Stage 2 would be qualitative, when thirty-six respondents who acknowledged that they had had a religious experience would be interviewed in depth, to explore their experience of religion as someone suffering with enduring mental health problems. The Stage 2 interviews would be recorded, transcribed in full and analysed in order to understand from a sociological perspective the function that religion performed in the lives of the respondents.

Sociologically it was a fascinating time to be undertaking research about people with mental health problems. Not only were we in a new millennium with a new emphasis on the rights of the individual, but the whole concept of being a 'patient' had altered radically during the latter years of the past century. The group of people who had been locked away from contact with society and had had all their rights removed were beginning to emerge as individuals, who not only had rights but were in fact able to contribute knowledge to professionals.

The asylums of my youth have gone and the ex-patients are slowly beginning to carve
out for themselves a position in society. This research relates the stories of people who are part of that transition, i.e. those who were once ‘patients’ in the long stay psychiatric hospitals and are now ‘service users’ attempting to integrate fully into society.

Looking at the religious lives of service users was also interesting sociologically because religious beliefs and practices in the general population had changed during the latter years of the last millennium. However, research shows that religion is still important for a significant proportion of people suffering with mental illness, although this was an area that had not been investigated when I started my research. Much of the present research that is being undertaken in this field is collaborative between people whom Trivedi and Wykes (2002:468) refer to as ‘user-researchers’ and ‘traditional researchers’.

The main research question in this study sought to understand from a sociological perspective what was taking place within the service users that made religion an important element in the lives of many of them.

What causes people with enduring mental health problems to look to religion, and what do they find there?

However, there were other research questions that I wanted to answer from the Stage 1 data, which would locate my sample within the general population and that of other service users. I wanted look at their religious beliefs and practices, and to see if gender played a role in their religious identity. I was also interested to know if they felt labelled as ‘mentally ill’ and/or ‘religious’, and what implication any experience of labelling had for their lives.

1. How similar or dissimilar was my sample of psychiatric service users to the normal population?
2. Was there a gender difference in the respondents’ views?
3. How did my sample compare with other groups of service users?
4. What part did religion play in the service users’ lives?
5. How many respondents reported having had a ‘religious experience’?
6. How did the dual labels of ‘mentally ill’ and ‘religious’ impinge on the service users’ lives?
7. How free were the service users to talk about their mental health problems and religious ideation?
This thesis explores the place of religion in the lives of people with enduring mental health problems from their own perspective. It gives an insight into the interaction between their experiences of spirituality, the spiritual realm, and religious practices and their experience of mental illness. It looks at how they relate to other members of society particularly with those within religious organisations, and how others respond to them as mentally ill and religious.

Out of the close and detailed exploration of this group of people, I argue that for those participants in my research for whom religion and religious experiences are important in their lives, religion provides the 'repair of their protective cocoon' that mental illness breaches, and brings a form of ontological security that is much needed and is not furnished by the practices of medicine or science. This security flows from religion and religious experiences providing frameworks that enable service users to make sense of their illness and to locate it meaningfully in their lives, restoring order amidst the chaos that characterises severe mental illnesses.

Outline of the Thesis

Chapter 2 defines the concepts of 'mental illness', 'religion' and 'religious experience' in order to investigate the interface between mental illness and religion. Both mental illness and religion are complex areas that are enmeshed within the culture and socialisation of the population. Therefore, to understand the treatment of people with enduring mental health problems in England today, mental illness is explored from a sociological perspective, and the historical beliefs about it and the care of sufferers are outlined.

Chapter 3 presents the existing literature that relates to 'mental illness', 'religion' and 'religious experience', but finds it lacking in any research that examines the religious lives of people suffering with enduring mental health problems. No one has looked at the religious experiences of the mentally ill, and most research that investigates issues relating to religion for mentally ill people merely records their denominational affiliations.

Chapter 4 discusses the methodology employed in this thesis. It examines the sample group and relates the difficulties encountered when researching a vulnerable group of people who are protected by a series of gatekeepers, and whose mental state is fragile and unpredictable. It reviews the rationale behind filing in an interview schedule with the respondents in Stage 1 of the research, and tape recording the Stage 2 interviews.
Chapter 5 undertakes analysis of the data from the Stage 1 interviews to present an overview of the lives of the 100 respondents, with particular interest in their spiritual beliefs and practices. It compares elements of their lives to the general population and other service users.

Chapter 6 analyses the religious experiences of the sixty-seven respondents who acknowledged having had one. A framework is constructed to aid analysis, and each experience is coded to denote the classification and subsidiary division. The experiences are positioned in the lives of the respondents, and related to their religious profile.

Chapter 7 explores religious issues that emerged from the Stage 2 recorded interviews and shows the idiosyncratic frameworks of understanding that the respondents employed to make sense of their lives. Some used religion to create a framework that could contain and explain the chaos that their fluctuating mental illness caused, thereby restoring their ontological security.

Chapter 8 examines the use of language employed by the respondents to communicate with agents, such as medical staff, clergy and other service users, about their religious experiences, to help restore their ontological security and answer existential questions.

Chapter 9 concludes the thesis by reflecting on the long journey of discovery and the insights gained into the religious experience of people with enduring mental health problems. It explores the difficulties encountered when investigating such a vulnerable group of people. Drawing on Laing's (1959) and Gidden's (1991) concept of ontological security it is argued that a high proportion of mentally ill people look to religion to make sense of the chaos caused by their illness.

People without mental health problems often look to God and attend a religious service in times of personal crisis or fear, but return to their habitual lifestyle when the danger has passed. I hypothesise that crises occur on a regular basis in the lives of service users with enduring mental health problems, so they continue to look to God for security on an ongoing basis, hence their interest in religion.
Chapter 2
The Interface between Mental Illness and Religion

2.1 Introduction
With development of human rights and ideas about citizenship, it is generally argued that people living in England at the beginning of the third millennium who are diagnosed with enduring mental health problems should now be regarded as no different from any other citizen. However, despite living and being treated in the community instead of a psychiatric hospital, and being referred to as ‘service users’ or ‘clients’ instead of ‘patients’, they are not fully integrated into society and remain a stigmatised and stereotyped group of people. As the large Victorian mental asylums closed and the mentally ill were discharged into the community many ex-patients became lost and ignored, living in drab bed-sits, seaside boarding houses or on the streets and their plight became an indictment of the government’s policy of ‘Care in the Community’ (Laurance 2003). As Laurence notes: “The ‘dangerous lunatics’ of popular prejudice are more likely to be sad and frightened human beings” (2003: 40).

Porter (2002) argued that all societies judge some people to be ‘mad’, and he saw this as part of a process which marks out those who are different and possibly dangerous. By classifying some people as ‘sick’ it acknowledges that the rest are ‘whole’, thus giving them a superior status and boosting their self-importance at the expense of the stigmatised ‘sick’.

This demonizing process may be regarded as psychologically and anthropologically driven, arising out of a deep-seated and perhaps unconscious needs to order the world by demarcating self from other... The construction of such ‘them-and-us’ oppositions reinforces our fragile sense of self-identity and self-worth through the pathologization of pariahs. (Porter 2002: 63)

However, it is the ‘self-identity’ and ‘self-worth’ of those labelled ‘mad’ rather than the ‘whole’ that is the concern of this thesis. Sadly, part of the reason why the mentally ill are not fully integrated into society is their loss of ‘self-identity’ and ‘self-worth’ because they stand between a stereotypic historical view of the mentally ill as ‘sub-human half-wits’, or even ‘demon possessed’, and the modern fear of ‘psychopathic murderers living in the community’. The British press, unlike their European counterparts, fuel the public’s fear of the mentally ill by using lurid headlines to
increase their sales: "'Schizo killer was a bomb waiting to explode', 'Doc freed psycho
to kill'" (Laurance 2003: xvii).

However, stereotypes never paint a true picture, and therefore it is important to look at
the historical understandings of mental illness to comprehend some of the foundations
of today's perceptions of the mentally ill.

This thesis examines one particular aspect of the mentally ill, their religious lives. To
understand why a high proportion of those with enduring mental health problems in
England express religious interests and needs it is necessary to examine the lives of
such people and comprehend the function that religion performs for them, both
historically and now. However, before examining the religious component of their lives
three concepts have to be investigated and defined.

This chapter will consider three concepts: 'mental illness', 'religion', and 'religious
experience'.

2.2 Historical Beliefs about Mental Illness

Roy Porter developed a comprehensive historical analysis of mental illness which will
be drawn upon in this chapter.

Madness, Porter argued, was "as old as mankind" (2002: 10) and was described in
religious stories, myths and legends; in the Old Testament King Nebuchadnezzar was
punished for his pride by becoming mad and living like an animal until his "sanity
returned" (Daniel 4:34). The Babylonians and Mesopotamians believed that certain
disorders were caused by "spirit invasion, sorcery, demonic malice, the evil eye, or the
breaking of taboos" (Porter 2002: 12), and possession of an individual was both a
judgement and punishment from the gods. Diseases were treated by priest-doctors who
had recourse to auguries, sacrifice and divination for diagnosis and remedies. At this
time religion was integral to their understanding of mental illness.

Porter (1996:11) claimed that the Greeks' understanding of the psyche in the fifth and
fourth centuries BC was the basis of the Western way of thinking about minds and
madness. Before this time people were seen as manipulated by forces beyond their
control: by gods, demons, the fates and the furies. Some Greek philosophers viewed
madness as a sickness of the soul, but other doctors of the Hippocratic tradition argued
that it was a physical sickness with no supernatural cause. They saw the 'sacred disease'
of epilepsy not as a visitation from the gods but as a result of natural causes, which led
them to believe that other abnormalities, such as mental disorders, were caused by
diseases and required physical medicine.

Medieval Latin Christendom absorbed both Greek theories of the cause of madness, 'soul sickness' and 'disease', but perceived them as under the will of God. Instead of a Greek man-centred philosophy, Christian theology saw madness as a war waged between God and Satan for the possession of the sufferer's soul, and declared that the human race was surrounded and outnumbered by other-worldly spiritual beings (Porter 2002).

In traditional pre-industrial societies conceptions of health and illness did not differentiate between disorders of the mind and body. Many saw illness in religious terms and linked sickness with sin. Treatment, such as drilling holes in the skull to allow evil spirits to escape (Pilgrim and Rogers 1999:119), is barbaric to our modern notions and was often only available to the elite. Labourers and peasants relied on herbal and folk remedies that were passed down through the generations, and were often administered by the local wise man/woman or the witch doctor. It was not until the eighteenth and nineteenth centuries that 'scientific' medicine emerged and a biomedical model of illness was established, with doctors taking the place of the wise men as the possessors of knowledge and the providers of cures.

Until the end of the Middle Ages the family was responsible for the mentally ill who were seriously disturbed, but the inoffensive deranged were allowed to wander, although they were shunned by most people because evil spirits were thought to leave the sick person and to possess any who came in contact with them. No special provision was made for the mentally ill until, as Porter argues, there was a long-term shift in policy toward people "displaying delinquent and dangerous traits" (Porter 1996:13) and the mentally ill were included in a general rise of exclusion of such people.

There was a new orientation towards the sick. Foucault (1965) saw the late eighteenth century as a time when illness went through a process of social re-construction and became part of the system of state control. He described the incarceration of those marginalised by society as 'the Great Confinement', when all over Europe institutions such as prisons, schools, workhouses and madhouses were built to contain those who did not conform to societal norms.

Mental illness therefore has been intertwined with religion throughout history: its cause was frequently conceived in spiritual terms and those that treated it were often religious. Although there were religious mental states that were believed to emanate from God it
was the darker side of religion that was usually blamed for insanity, so that the sick were shunned for fear that the demons possessing the mad person should attack and contaminate the well.

According to Foucault mental illness is a social construct, therefore its conception and treatment varies at different times and in different societies. Although he sees the mad being swept up in a Europe-wide ‘great confinement’ along with the poor and petty criminals, who he maintains are defiled by “unreason” (Porter 2002:92), Porter finds Foucault’s explanation of the treatment of the mentally ill “simplistic and over-generalized” (2002:93). Porter argues that although in the seventeenth century France followed an absolutist approach and confined the mentally ill along with other ‘unreasoned’ deviant populations, not all countries followed this pattern. In particular post civil war England followed a democratic style and institutionalization was not the main way that the mentally ill were cared for. State-led sequestration did not appear in England until the nineteen century (Porter 2002).

2.3 Care of the Mentally Ill in England

Evidence suggests that in the early medieval period the insane in England were treated alongside the sick of other categories, mostly at shrines (Murphy 1991). Windows in Canterbury Cathedral depict miracles worked at the tomb of St Thomas à Becket: the saint was seen dealing with swollen feet, epilepsy, fever, wounds, leprosy, congenital lameness, dropsy, blindness, death by drowning, and insanity. The Holy Trinity Hospital in Salisbury showed on the foundation deed that thirty beds were provided for the mentally ill: “…the mad are kept safe until they are restored to reason” (Murphy 1991).

A petition in 1414 for the reformation of hospitals stated that they existed, among other things, to maintain those who had ‘lost their wits’. Some almshouses on the other hand prohibited admissions of the insane, suggesting that in the absence of such a ban they would be expected to take cases of that kind. It appears that the provision for the insane was not unlike today: the district general hospital with a psychiatric department.

From the Middle Ages up until the seventeenth century people thought to be mad were dealt with according to the means of the sufferer’s family. Most mentally disordered people were cared for by their families although many ended up in jails. Many became drifting, destitute vagrants dependent on charitable handouts or begging, until the Poor Law of 1601 gave every parish the responsibility of maintaining those incapable of
looking after themselves. This was the first era of ‘community care’. There was one nationally known institution which specialised in the short-term treatment for lunatics, Bethlem Hospital in London: it was founded in 1247 as a priory but started providing care for the insane in the fifteenth century, and still does today.

Mad people wandering the streets were a common sight in the seventeenth century. Porter (2002) argued that the intermingling of the lunatics with others was beneficial in that it did not treat the mad as alien beings, which in turn helped preserve some sense of normality for them. This he felt was in line with the Christian notion that all men, including the insane, were created in the image of God.

The Vagrancy Act of 1714 contained the first statute law providing for the confinement of the dangerously insane, as they were incarcerated with all vagrants but were excluded from whipping. After many abuses in private madhouses became public knowledge the amended Vagrancy Act of 1744 was passed, to protect the insane and provide them with some care. Small specialist hospitals and early forms of asylums were built in the first half of the eighteenth century and Thomas Guy built a wing of his hospital for ‘incurable lunatics’. However, by the end of the eighteenth century care at home remained the norm with under 5,000 lunatics in private madhouses nation-wide, or in local parish ‘houses of correction’ (Murphy 1991:30).

The general public knew and cared little about mental disorder, except in so far as the more visible sufferers who were living on the streets were a burdensome public nuisance. However, in 1788 George III went mad and his management became a subject of public interest. Like today, a high profile case brought mental illness to public notice. Bean and Mouser (1993) felt that his treatment exemplified this era when patients were no longer treated as human beings: he was encased in a machine that allowed no movement, and was frequently starved, beaten, and verbally abused.

Reformers pressed for improvements in standards of care of the mentally ill and the Lunacy Act of 1808 encouraged counties to establish public asylums for the insane, but little happened. When the Poor Law Amendment Act of 1834 reduced parish relief for those living at home, in order to qualify for assistance from the parish the poor - who often included the insane, had to enter a workhouse. ‘Care in the community’ ended when the local parishes combined and established one large workhouse for each area. However Murphy (1991) noted that the guardians of the workhouses found the lunatics to be disruptive and wanted them removed.
Jones believed that there were humanitarian ideals behind the reform movement that led to the passing of the Lunacy Act of 1845, which directed the mandatory construction of lunatic asylums in every county. She felt that the reformers had

...roused the public conscience of mid-Victorian society, and had set a new standard of public morality by which the care of the helpless and degraded classes of the community was to be seen as a social responsibility. (Jones 1960:149)

Porter (1996) too saw the reform in a humanitarian light and did not see the institutionalisation of the mad to be punitive or repressive, but rather considered that segregating the mad benefited everyone. However, critics attacked mechanical restraints, such as that used on King George III, as cruel and unproductive and in the late eighteenth century the 'moral management movement' advocated kindness and reason to restore the mind of the insane. Many early institutions were modelled on the moral treatment regime of the York Retreat, where physical restraints were discarded and patients were treated humanely in a rural setting. They attempted to treat their inmates as "potentially curable human beings" (Porter 1996:19), believing that treatment might restore reason to the alienated mad.

In 1875 central government first became involved in financing a welfare service by subsidising counties in maintaining 'pauper lunatics' in asylums. The great Victorian institution boom had begun, and by the end of the nineteenth century the pattern of Britain's mental hospitals was established for nearly one hundred years. By 1880 there were sixty-six county and borough asylums with an average 802 inmates and 86,067 officially certified cases of insanity, more than four times as many as forty-five years earlier (Gibbins 1988).

Scull (1979) regarded the asylums as a mechanism by which society could shed its responsibility for troublesome and unwanted people. Conditions in some mental hospitals in the 1940s and 1950s were appalling, often worse than when the hospitals had been opened a century earlier. Although in innovative hospitals the number of residents began to fall by the late 1940s, the peak bed occupancy was in 1954 and declined at a relatively even rate, due to changes in public attitudes to mental health problems, the rising influence of psychiatry as a branch of medicine and the introduction of tranquilliser drugs (Murphy 1991:46).

Glennester (1995) viewed the inspiration for the social legislation passed between 1944 and 1948 as being generated in a period of outstanding social change and national
danger, and believed that it constituted one of the most coherent and long-lasting institutional legacies in modern British history. The National Health Service was conceived during the war (Beveridge Report 1942) when the coalition government accepted the revolutionary notion of free care for all. The initial proposals for the NHS had intended to exclude mental hospitals because the Board of Control, which monitored them, felt that they were too dissimilar to general hospitals to amalgamate them into one system and to do so would have required legislation, which was not possible in wartime. Pressure, in particular from the British Medical Association, who were opposed to any hospitals being controlled by local authorities, resulted in the mental hospitals being included in the national system (Freeman 1999).

The resultant amalgamation had a far-reaching effect on the way that the mentally ill were to be treated. 'The Future Organization of the Psychiatric Services' report 1945 proposed that the treatment of the mentally ill should be no different to that of the physical ill, which improved the status of psychiatrists as they became incorporated into the structure of general medicine. It was at this stage that psychiatry became absorbed into a treatment framework dominated by general medicine and surgery and took on the 'medical model'. This was reinforced by the introduction of psychotropic drugs in the early 1950s, and pharmacotherapy became their dominant treatment to the exclusion of more socially orientated programmes (Jones 1993).

The Mental Health Act 1959 heralded a policy shift (Allsop 1995): it modernised the approach to mental illness and introduced new and extended community mental services with the intention of providing a range of homes, hostels and social clubs. In 1960 the Minister of Health, Enoch Powell, forecast the elimination of mental hospitals and the 1962 Hospital Plan launched the official closure programme. However, the early 1960s saw the focus on closing the asylums rather than on community care. It was hoped that former mental patients would be able to resume their role as citizens in the community, and that if returned quickly after an acute episode of illness, chronic disability would be prevented. The optimistic convictions of the time made it difficult to believe that some patients might require lifelong support in some sort of sheltered environment, because the community was considered a place to which patients were sent after medicine had 'cured' them. However, in 1961 Titmuss (Means and Smith 1994) warned that simply promoting the slogan of 'community care' would not help the mentally ill if resources were not available in the community. He feared that patients would be resettled from the care of the hospital staff to untrained people in hostels with disastrous consequences.
Sadly, in many instances his fears were realised.

The era of ‘community care’ had begun and has now become a reality. However, Murphy (1991) described the period 1962-1990 as ‘the disaster years’ because by 1979 there were 60,000 fewer residents in large mental hospitals than there had been in 1954, but very few services at all existed in the community. By the mid 1970s the failures of the philosophy of ‘community care’ were becoming apparent and it was realised that vulnerable mentally ill people would need long-term support to be maintained in the community.

Many become lost in the interstices of social life, and turn into drifting inhabitants of those traditional resorts of the down and out, Salvation Army hostels, settlement houses, and so on. Others are grist for new, privately-run profit oriented mills for the disposal of the unwanted – old age homes, half-way houses, and the like. (Scull 1977:152)

In 1983 the Mental Health Act was passed which contained most of the powers affecting people suffering with mental health problems, and provided the legal instrument to enable society to act in the interests of, and on behalf of, patients who were diagnosed as having abnormal mental conditions. The Act defined four conditions that constitute mental abnormality: mental disorder; mental impairment; severe mental impairment and psychopathic disorder. Promiscuity or immoral conduct, sexual deviancy or dependency on alcohol or drugs were not regarded as ‘mental disorder’, as was the case when the lunatic asylums were filling their beds with the community’s problem people during the late nineteenth to mid-twentieth century.

Following publication of the Government White Paper ‘Caring for People: Community Care into the Next Decade’ (1989), England replicated the American notion of ‘Care Management’, as a way of providing services for vulnerable people including the mentally ill. A manager was appointed to assess each person’s needs and produce a ‘package of care’, although as Payne (1999:254) points out, in common with other British policy provisions this did not create a right to receive the service. Another policy change was introduced at this time in the ‘NHS and Community Care Act 1990’ with the establishment of an internal market within both health care and social services, with the creation of ‘purchasers’, who were responsible for purchasing service from ‘providers’ who were responsible for the provision of the actual services. Payne (1999) asserts that the lack of piloting either policy change caused great difficulties for the mental health service, in particular because the changes left the medical care of the patients with the health authorities and social care with the social services, and the
inevitable consequence was a fragmented service.

With the run down of psychiatric beds following the closure of the asylums there was increasing debate over alternatives to in-patient care and treatment of the severely mentally ill, with the public becoming concerned by the risk posed by some mentally ill people living in the community. Some high profile cases involving mentally ill people who had been discharged from hospital precipitated the 1995 Mental Health (Patients in the Community) Act, which introduced supervision after discharge for patients who had been detained in hospital under a section of the 1983 Mental Health Act. In the same period the Department of Health introduced ‘at risk’ or ‘supervision registers’ of those thought to be at risk of committing a serious crime, or harming themselves through suicide or self-neglect.

Laurence argued that the danger that mentally ill people posed to the public was at the heart of the White Paper ‘Reforming the Mental Health Act’ December 2000, as it proposed compulsory treatment for those in the community, not just those in hospital, and a new power to detain people considered to be dangerous. The Royal College of Psychiatrists (RCP) believed that it altered the balance from treatment towards “social control and risk management” (Laurance 2003:53). When the draft Mental Health Bill in June 2002 retained the proposal for detaining dangerous people with personality disorders again the RCP complained that the role of psychiatry was shifting from therapy to social protection, and they considered that instead of it being a Mental Health Bill it was more a ‘Public Order Act’. They feared that it would increase stigma of the mentally ill, and indeed would be counterproductive because it would discourage sick people from seeking help with their mental illness. Most reports looking at violent incidents perpetrated by the mentally ill found that the person, usually male, had been treated by the medical and social services but had lost contact with them. Evidence (Laurance 2003) showed that service users were most likely to be compliant with treatment when they were involved with their care and were not coerced. Therefore legislation that did not take into account the mentally ill person but only reacted to public pressure would not achieve its desired aim, and the public would be put at greater risk because the very small proportion of potentially dangerous mentally ill people would not seek help early with their symptoms and receive treatment.

Despite the reformers’ work and medical advances, mental illness still brings immense suffering to both service users and their relatives. Society’s treatment of the mentally ill may have changed to fulfil the requirements of legislation, but laws cannot alter deeply
held convictions and attitudes of the population towards those with mental illness.

2.4 Religious Care of the Mentally Ill in England

Historically England was a Christian country with societal norms grounded on Judaic/Christian principles. From the Middle Ages onwards monasteries saw the care of the sick as a function of their Christian ethic and provided accommodation and spiritual care for sufferers. However, it was the spiritual needs of the physically sick that were cared for not those suffering mental illness. Rollin (1994) postulated that the reason for this was the belief that the mentally ill had lost their reason, putting them on a par with animals and therefore incapable or unworthy of communion with God.

The Bible itself gave reasons to believe that the mentally ill were set apart from society, being wild and dangerous. There were several Biblical stories of people being possessed by evil spirits and needing deliverance before they could be brought back into association with other people. Mark told of Jesus and his disciples being met by a man with 'an evil spirit' (Mark 5:2). He was evidently extremely strong and had been violent for some time:

...no-one could bind him any more, not even with chain. For he had often been chained hand and foot, but he tore the chains apart and broke the irons on his feet. No one was strong enough to subdue him. Night and day among the tombs and in the hills he would cry out and cut himself.
(Mark 5:3-5)

The man fell at Jesus' feet and shouted at him. When commanded to by Jesus the evil spirit left the man, but went instead into a large herd of pigs which rushed over a cliff and were drowned in a lake. The man was found by the onlookers sitting with Jesus and his disciples “dressed and in his right mind” (Mark 5:15). The local inhabitants were terrified by what they had seen happen to the man and the pigs. Some Christians today would take literally the content of the story, believing that mentally ill people can be possessed by evil spirits and for healing to take place they needed to be exorcised by religious means. This would reinforce Porter's (2002:63) notion of the construction of 'them-and-us' oppositions: the Christians on God's side and the mentally ill on the Devil's.

Another story told of Jesus answering the request of a father to heal his son because:

...a spirit seizes him and he suddenly screams; it throws him into convulsions so that he foams at the mouth. It scarcely ever leaves him and is destroying him. I begged your disciples to drive it out, but they could not. (Luke 9:39-40)
This appears to be a picture of a child with grand mal epilepsy, which Jesus healed by casting out a demon. “Jesus rebuked the evil spirit, healed the boy and gave him back to his father” (Luke 9:42). Again this notion of demon possession causing a medical condition stigmatises the sick as being evil.

Whereas in some cultures those with mental illness were revered as mediums or shamans in contact with the spirit world, in England over the centuries the mentally ill were liable to be excluded as contaminating society. Although village communities often coped with the local ‘idiot’, these people were more likely to have suffered from a low intelligence than a mental illness. As has been noted, from the nineteenth century until the 1990s the mentally ill were removed from the community and institutionalised out of public view.

Lord Shaftsbury, one of the English Evangelicals who were responsible for much social change early in the nineteenth century, deemed it “an instrument of Christianity to bring lunatics within the compass of the Established Church” to ensure their personal salvation (Rollin 1994). This necessitated having an accessible place of worship for all patients, so chapels became a prominent part of the asylum architecture. Legislation recognised the change in the status of lunatics and required Divine Service to be performed for the solace of the patients, and Section 38 of the Treatment of Insane Persons Act 1828 trusted that: “…the hopes and consolations of religion may soothe and compose the minds of patients, and subdue the malady under which they are suffering…”. However, the medical personnel were less convinced than the legislators of the benefits of religious practices for the well-being of their patients. John Conolly believed divine worship to be relevant to the ‘moral treatment’ of the insane but he wrote:

I believe the experience of all chaplains of asylums has taught them that there is great difficulty in ascertaining to what extent their most anxious endeavours are really serviceable. (1856 reprinted 1973 and quoted in Rollin 1994)

He felt that some literature could have malevolent effects on the fragile minds of the insane, so the physician should inspect all books before circulation. He also required a list be submitted for the doctor’s approval of those patients wishing to receive communion, so that “none should be admitted whom the ceremony might disturb or who might in any way interrupt its solemnity” (ibid).

Like Conolly, Dr Unwins, the physician at Peckham House Asylum Surrey, did not
believe that the patients could benefit from religious instruction, and he was very opposed to religion being introduced into his hospital. He wrote:

In regard to religious instruction of lunatics, where the mind is completely alienated, I am of the opinion also that the anticipation of those who, in the best spirit, proposed it, will be miserably disappointed. Even the daily reading of prayers is nugatory, if not farcical, before an indiscriminate assembly of mad persons. ....Beyond these probable and by no means certain benefits it has appeared to me ... that the legislative provision of a spiritual instructor for a madhouse has been founded rather upon benevolent feelings, rather than much knowledge of the constituents of insanity. (Unwins 1963 quoted in Rollin 1994:628)

It should be noted that the provision of religious services in asylums in the nineteenth century was exclusively of the established Church of England and arrangements were made only on an ad hoc basis for the spiritual needs of non-Anglicans.

The role of religion in the treatment of patients reached its peak in the mid-nineteenth century, but was followed by a steady decline. Although the reasons for this were complex, one factor was the waning of the Evangelical Movement with its influence in promoting 'religious therapy'. Another factor was that asylums were simply microcosms of the wider society and reflected the steady reduction of the importance of religion during this period. However, the element that was most instrumental in demoting the prominence given to religion was that many of the asylum doctors were unconvinced of the benefit to their patients of spiritual matters, and with less pressure from without, religious practices were allowed to contract by default. Facilities were there for those who sought the comfort of the Church but unlike earlier times little attempt was made to spread the Gospel. Evidently the patients, or possibly the staff who cared for them, favoured amusement rather than religious practice. The Commissioners in Lunacy 1906, for example, noted that at Horton Hospital 25% attended weekly services in contrast to 56% who enjoyed the weekly entertainments (Rollin 1994).

Within the old psychiatric hospital where many of my respondents were treated there were full time clergy who visited the wards and held services in the hospital chapel. When the hospital closed in 1996 the Church of England clergy were joint-funded by the NHS Trust and the local Church of England diocese to continue providing support to the service users in the community: special services and Christian clubs are run in a community church for those with mental health problems and learning difficulties. For some this level of care is needed, as they do not feel welcome and accepted in the community churches.
2.5 Sociological Perspectives of Mental Illness

As has been shown, historically much emphasis was placed on the supernatural as a cause of mental illness. This view lingers on in the socialisation of those who were brought up in a Judeo-Christian society, particularly amongst those within fundamentalist religious groups. One reason for this was the lack of any other explanation of why some people should have different thought processes and an alternative interpretation of reality to the societal norm.

Sociologists have not looked to religion as causative of mental illness, although they were divided about the precipitating factors. Three main explanatory perspectives emerged: that of social causation; social constructivism; and societal reaction. However, as Pilgrim and Rogers (1999) noted, there were no boundaries and much overlap between the different theoretical viewpoints.

The social causationists who saw society itself as the main cause of mental illness accepted the diagnosis of medical conditions, such as schizophrenia and manic depression, as a given fact but explored how social factors may have contributed to the onset of mental disorder. They were concerned with the relationship between social disadvantage and mental illness and looked at a number of factors that were disadvantageous to sound mental health. High on the list were 'social class' and 'poverty', but other variables such as 'gender', 'race' and 'age' were also considered important in this respect when looking at psychiatric populations.

Class and poverty were seen as precipitating causes of mental ill health as early as 1939, when Faris and Dunham (1939) studied patients admitted to hospital from different parts of Chicago. They found higher rates of patients suffering from schizophrenia, alcoholism and organic psychosis in groups from the poor areas of town, and the diagnosis of schizophrenia was seven times higher in the poor inner city areas than in the middle-class suburban areas. They concluded that the combination of poverty and a lack of social cohesion had precipitated the illness, seeing people who had become socially isolated during childhood as vulnerable to breakdown. They formulated the social isolation theory of schizophrenia, which saw the stress of poverty and social disorganisation as a cause of psychotic breakdown. Certainly mental illness can put a great strain on relationships with the consequent breakdown of marriage, and Gerard (1953) found that divorced and single people who already had a diagnosis of schizophrenia tended to move to inner-city areas.
Epidemiological evidence pointed to people suffering from schizophrenia being over-represented in the lower-classes (Dunham 1964) which begged the question ‘why’? Two hypotheses emerged: that of ‘social drift’ and ‘opportunity and stress’ (Pilgrim and Rogers 1999). The theory of ‘social drift’ postulates that mental illness incapacitates peoples’ social competence, which affects all areas of their lives and in particular their relations with other people causing amongst other things loss of employment. This can cause ‘drifting’ into poorer urban areas to live, because they cannot afford more affluent neighbourhoods, and also ‘drifting’ down the social scale. Without money and with poor social skills maintaining a higher-class lifestyle is problematic.

The second theory suggested that ‘stress and opportunity’ differentially affected people in the lower classes compared to the middle and upper classes. This could be accounted for by material differences: poor people lived in deprived areas with higher crime rates, more traffic and worse sanitation than the more affluent; their housing was more cramped, and more likely to be dirty, damp and poorly maintained; their diet and physical health were poorer; access to and choice of education was inferior to that available to the upper classes; and employment opportunities were likely to be restricted to jobs that offered little personal control. Phillips (1968) looked at the quality of life in different classes and found that people in the lower classes had lower self-worth and esteem, which he felt was due to lower class people suffering proportionately lower rates of positive life experiences to negative life experiences. The lower classes therefore had fewer positive experiences to cushion them against stress and therefore made them more susceptible to mental ill health. In his longitudinal study Myers (1975) found that in all social classes the greater the number of life events, both negative and positive, the greater the likelihood of mental ill health. However, because higher-class people experienced a higher proportion of positive life events than negative ones this helped to protect them from psychiatric symptoms more than in the lower classes where negative experiences outweighed the positive ones.

However, Pilgrim and Rogers (1999) argued that although social stress can be demonstrated to be correlated with social class it cannot be proved to cause schizophrenia, although there is epidemiological evidence that social stress affects rates of recovery and relapse. Stress may well precipitate relapse but it cannot be shown to cause the first breakdown, although the connection between stress and class may explain why recovery rates are poorer in the lower classes.

Another theory of the cause of mental illness is proposed by the ‘social
constructionists', who examined the production of knowledge and argued that definitions of mental illness are socially constructed and act as mechanisms of social control. In their view reality was not self-evident, stable and waiting to be discovered as the positivists presumed, but was a creation of the human mind. Therefore the meaning that an object had for an individual was not a given fact but a social construction, and objects could hold different meanings in different societies, and did not exist at all in some societies.

Some social constructionists rejected the idea that psychiatry was a scientific discipline that was unaffected by social forces (Pilgrim and Rogers 1999), and they saw the construction of disease categories as shaped by race and culture. Scheff argued that unlike the medical model of disease where the processes were culture free, symptoms of mental illness were violations of cultural rules:

...concepts of mental illness...are not neutral, value-free, scientifically precise terms but are the leading edge of an ideology embedded in the historical and cultural present of the white middle class of Western societies. (Scheff 1996:65)

The fact that behaviours that constitute societal norms are 'Western, white and middle class' can cause a problem for those who come from a different background. Ranger (1989) found that British psychiatrists attached the label 'cannabis psychosis' selectively to Afro-Caribbean people when they did not understand their behaviour. Psychosis is defined by the Royal College of Psychiatrists as 'a mental illness which cannot be understood as an exaggerated or ordinary expression', but as it was often the psychiatrists who decided what constituted 'an exaggerated or ordinary expression' and based their diagnosis of mental illness as something beyond that, their concept of normality was the standard by which behaviour was judged. Normality for a white middle class Englishman would no doubt be very different from that of a young person from an Afro-Caribbean background, as would be the way they expressed themselves. Ranger felt that the difference in culture accounted for the number of Afro-Caribbean people being diagnosed as psychotic, reasoning that within the Caribbean culture their behaviour may not have violated any cultural norms and they would not have been labelled as mentally ill. There is an extensive literature on this topic (Knowles 1991; Littlewood 1980) which will not be examined here because it was not a dominant issue for my sample.

As the concept of 'ordinary' is based on the dominant groups in society in terms of numbers, status and power, this will vary in different cultures, and therefore psychiatric
diagnoses can be argued to be socially constructed (Pilgrim and Rogers 1999).

The third major sociological perspective regarding mental illness was the ‘social reaction’ theory, which focussed on deviant roles and identities and questioned why only some actions were seen as symptoms of mental illness, and some people were labelled as mentally ill but not others.

Scheff (1966) argued that the notion of being mentally ill was a social role, and the reason for being labelled as such was due more to the peoples’ reaction to strange behaviours rather than to the symptoms themselves. However, the visibility, quantity and intrusiveness of the symptoms affected the stage at which a person would be labelled. According to labelling theorists it was common for people to deny that someone had deviated from expected behaviour in order to keep the person in their existing role. In one study (Yarrow, et al. 1955), wives of husbands with schizophrenia rationalised and ignored aberrant behaviour for varying periods of time before seeking help. Not until their strange behaviour became intolerable did the wives reassess the situation and a diagnosis of schizophrenia was made, thus giving the husband the deviant role of ‘patient’.

During the 1960s labelling theory became fashionable in mental health and was concerned with recording the ways in which the ‘patient role’ was negotiated and maintained. The work of Becker (1963) looked at ways in which ‘labels’ were used by those in a position of power to define behaviour. Giving a person a label of ‘crazy’ or ‘nutter’ defined their behaviour as deviant, by pointing out that it did not conform to social norms, and in so doing attributed characteristics to the person labelled – this Becker termed ‘primary deviance’. The label could then make the person take on the image of the label – ‘secondary deviance’. Being given the label of ‘mentally ill’ would be ‘primary deviance’, but if the label were accepted the person would take on the ‘patient role’, which is ‘secondary deviance’ and much more damaging because it is difficult to remove. However, it was the fact of being labelled by the powerful person or group that defined the action as deviant not the action itself. As Becker stated:

...deviance is not a quality of the act a person commits, but rather a consequence of the application by others of rules and sanctions to an ‘offender’...Deviance is not a quality that lies in the behaviour itself but in the interaction between the person who commits an act and those who respond to it. (Becker 1963:9)

Thus a person ‘sectioned’ under the Mental Health Act 1983 by a psychiatrist would be so labelled.
Once a person was labelled their identity and social status was altered. Goffman (1961) spoke of patients going through a 'status degradation ceremony', when their old identity was stripped away and a new one assumed, which was then internalised by the patient. The person took on the patient role, and others interpreted his behaviour in terms of his new role.

Horwitz (1977) found that women were more likely to be labelled than men. He also made the point that the greater the difference between the labeller and the labelled the more likely it was to happen and the more devaluing the label ascribed.

Scheff argued that within a society any variation from the expected norm could pose a threat to the social status quo, and if not resisted could lead to the erosion of current convention. He felt that those who wished to conserve their culture would look to “extra social sources of legitimacy” (Scheff 1996:69), which in the case of religious societies would be supernatural. In the religious Middle Ages God’s commands in the Bible, which were interpreted by the Catholic Church, provided the reference point to legitimise social order, but in modern societies science has taken the place of religion. Scheff contends that, as medical professionals are the representatives of science that most people have dealings with, when they label nonconformity as mental illness they legitimise the social status quo.

The sociological theories helped to explain the causes of mental illness and the effect that being diagnosed as having a psychiatric illness had on individuals; they were likely to be disadvantaged socially, materially and mentally. Added to these negative states they took on a new unwelcome identity. Scheff (1996:67) noted that “stereotyped imagery of mental disorder is learned in early childhood”, so to be labelled as mentally ill brings with it not only external social sanctions, but internal anxieties about becoming one of the group of people that early socialisation has taught are stigmatised as ‘abnormal’.

However, not all sociologists accepted the medicalization of ‘moral-social’ problems into psychiatric illness, and their arguments shaped ‘the anti-psychiatry movement’ of the 1960s and 1970s. Laing (1959;1967) stimulated a debate when he hypothesised that even severe forms of disturbance, like schizophrenia, could be seen as meaningful responses to difficult, ‘sickening’ social circumstances. In the United States Szasz (1971) argued that the concept of mental illness was a ‘myth’ and rejected any physiological basis for what he believed was a value-laden label. He contended that by labelling an individual as mentally ill society sanctioned a wide range of coercive
actions, including involuntary committal to a mental hospital and forced compliance with drug therapy. He perceived psychiatrists to be agents of society's drive to control deviant and abnormal behaviour, and asserted that medicine had become the new religion and that those labelled mentally ill were scapegoats as the witches had once been.

The anti-psychiatry movement expressed antipathy to the mental hospitals as therapeutic institutions and Goffman's texts on Asylums (1961) and Stigma (1963) combined two halves of a critique of the care of the mentally ill. He saw mental hospitals as an example of 'total institutions' where patients were isolated from society and were supervised by staff who rigidly controlled the social environment, enabling the patient to be re-socialized or coerced into compliance with the staff's requirements. The "abasements, degradations, humiliations, and profanations of degradation of self" (Goffman 1961:14) experienced in asylums reinforced the powerful negative social label, or 'stigma', that was applied by others so that patients accepted them as their social identity.

The institutions may now have gone but service users are still isolated, not from society but within society, and as has been noted, attempts are being made to legalise the continuation of the coercion of service users to comply with medical treatment within the community. The stigma of being labelled as mentally ill is still as damaging as when Goffman analyzed its effects in the 1960s.

The term stigma conventionally refers to any attribute, trait, or disorder that marks an individual as being unacceptably different from the 'normal' people with whom he or she routinely interacts, and that elicits some form of community sanction. (Scambler 1998:1054)

Goffman noted three different forms of stigma: abominations of the body; character blemishes; and tribal stigma of race, nation and religion (1963:14), but distinguished between stigmas that were evident and those that could be hidden. The effect on the person of having a known stigma would be to induce a "discredited" identity, whereas those whose stigma could be concealed would suffer the anxiety of being discovered and were therefore "discreditable". Unfortunately, he noted a capacity for the stigma to spread to close connections such as family and friends as if contagious ("courtesy stigma" (1963:44)), which is reminiscent of the historical notion that evil spirits could leave the mentally ill person and contaminate those in proximity.

However, the concept of 'normality' is problematic. Goffman (1963:15) described
"normals" as people who "do not depart negatively from the anticipated expectations at issue", which begs the question: 'who defines the anticipated expectations?' Normality is therefore culturally constructed and socially situated. A religious zealot living in a fanatical religious sect would be considered normal to those within the commune because their interests, behaviour and speech would be common to them all. However, the same person interacting with people outside the sect could be considered abnormal and may be rejected as deviant. The same can be true of mental illness. Hyper-excitability and shouting in a shop may cause a person to be stigmatised as mentally ill, but displaying the same behaviour at a football match would be considered normal. It is therefore the context in which the behaviour occurs that governs whether it is regarded as normative.

Sayce (1998) argued that British service users face pervasive discrimination in all areas of life due to stigma: in work; housing; parenting; obtaining insurance; and even acquiring a driving licence. However she agreed with Oliver (1992) that the conceptual framework of stigma is not helpful when looking at the negative effects of having a psychiatric diagnosis. Sayce and Oliver felt that concentrating on stigma focussed attention on individual self-perception and micro-level interpersonal interactions, rather than looking at societal exclusion of the mentally ill. They preferred to turn to structural notions of 'discrimination and oppression' to bring into the open the hidden forces that keep the mentally ill suppressed.

2.6 Concept of Mental Illness

The study of mental illness - 'psychopathology' - was, according to Rodney Stark, "one of the more elusive and value-laden concepts in social science" (1971:167). Conditions that are defined as illness vary in different cultures, and indeed actions that could be symptomatic of disorder within the same culture can be considered normal in a different situation. Muttering to oneself, seeing visions and kneeling on the floor could be seen as a mental disorder if performed in a railway station whereas in a church may be viewed as normal behaviour. Illness is therefore socially constructed.

Horwitz and Scheid (1999) defined 'mental disorders' in terms of the disruption to social interactions caused by some abnormal mental states, and pointed to the fact that there is an arbitrary threshold of measurement which changes trivial disturbances into something which disrupts relationships. They proposed that it is therefore the individual's relationship to others that operationally defines the threshold for the
presence of disorder. This concentrates heavily on aspects of socialisation without looking at the wider disruption to the person, and it could also be argued that not all mental illness disturbs relationships, but many other factors can.

Looking to a wider picture of the disorder that mental illness can bring Schumaker saw mental health and mental illness as a continuum that was tied to the concept of normality. However, like Stark, he was aware that he was dealing with an elusive concept due mainly to the language used to describe and judge behaviour. For him abnormality was:

...personal suffering; maladaptiveness, wherein a behaviour interferes with individual or social well-being; irrationality or incomprehensibility; unpredictability and/or loss of control; unconventionality; observer discomfort; and violation of moral or ideal standards. (Schumaker 1992:9)

Individually these notions could be ascribed to people without a mental illness, and personal suffering may or may not be present in mental illness whereas it can be evident in a normal person. Unconventionality and observer discomfort are very subjective categories and can be culturally determined, and ‘violation of moral or ideal standards’ begs the question ‘whose morals and ideal standards’ will define normality?

Another way of defining psychopathology is by considering what the humanistically orientated see as normal mental health, and realise how far short of this ideal the mentally ill fall. According to the World Health Organisation health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946). However Maslow and Rogers (Schumaker 1992) went further and felt that optimal living involved other characteristics to achieve ‘self-actualization’ such as personal growth and development, autonomous functioning, self-love, environmental competence, a degree of insight and wisdom, the exercise of rationality, and the realisation of one’s potential.

Many mental health professionals view mental health as a composite of emotion, cognition, perception and sensation and assess an individual’s mental state by their functioning (Schumaker 1992). However, when assessing the mental state of an individual what is normal is not self-evident but socially negotiated, and can reflect the power relationship between service user and professional. Invariably the value system of the more powerful will dominate, which can be particularly dangerous in a multicultural situation where societal and cultural norms differ.
In British law there are four categories of mental disorder: mental illness, mental impairment, severe mental impairment and psychopathic disorder, but mental illness is not legally defined. Pilgrim and Rogers (1999) viewed the legal understanding of mental illness in the absence of a definition to be parasitical on psychiatric opinion, and pointed out that psychiatrists are called upon to give an expert opinion in court when the plaintive is suffering from a mental disorder. However, because judges have no legal definition they sometimes used lay discourses if no psychiatrist is called. Judge Lawton in 1974 said that ‘mental illness’ are ordinary words of the English Language that have no medical or legal significance, and he referred to Lord Reid’s comment where a defendant’s mental state was questioned:

I ask myself what would the ordinary sensible person have said about the patient’s condition in this case if he had been informed of his behaviour? In my judgement such a person would have said ‘Well the fellow is obviously mentally ill’. (Pilgrim and Rogers 1999:11)

This lay conception of legal insanity has been called ‘the man must-be-mad’ test. While this might have been the understanding of Lord Reid it has to be remembered that he was a white upper class Englishman making a statement in the 1970s, and defining mental illness using this lay conception would be fraught with the danger of simple misunderstanding of cultural deviations.

Mental health professionals now work with standardized manuals of diagnostic criteria for identifying mental illness. The most commonly used manual in England is the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (1994). For the majority of mental disorders diagnostic classification is made according to the profile of the presenting symptoms, which together form the syndromes of mental illness.

Mental illnesses are divided into two main categories – psychoses and neuroses. The psychotic conditions are considered more serious and entail a disturbed sense of reality. They are usually characterized by severe symptoms such as delusions and hallucinations, and by a lack of insight into the condition. Schizophrenia is the most common form with symptoms of thought disorder, hallucinations of hearing, smelling, feeling or seeing, delusions and paranoia. It affects one percent of the population and usually develops in the late teens or early twenties (Fellowship 1996). Other psychotic disorders are schizoaffective disorders, paranoid states, affective disorders, mania and depressive disorders. Sims defines neurosis as a “psychological reaction to acute or continuous perceived stress, expressed in emotion or behavior ultimately inappropriate
in dealing with that stress” (2000:394), and stated that neurotic patients may experience disturbances of self-image and bodily symptoms without an organic cause. Psychiatric diagnosis tends to be hierarchical with psychoses taking precedent over neuroses, so that a person suffering from both schizophrenia and anxiety will usually be diagnosed as ‘schizophrenic’. Indeed in the eyes of the public the label of schizophrenia personifies the lay understanding of mentally illness.

2.7 Concept of Religion

The terms ‘religion’ and ‘spirituality’ are often used loosely and interchangeably. A simple differentiation would view ‘religion’ as describing the beliefs and practices of an organised church or religious institution, and ‘spiritual’ as an individual experience of a relationship with a transcendent force or being. However, for sociologists to be able to study religion it is important to have a working definition in order to identify what constitutes ‘religion’. As Hargrove points out ‘the definition we give to any phenomenon structures the questions we ask, the behaviour we observe, and the type of analyses we make’ (1979:4). There is a balance to be struck between on the one hand using a definition which is broad enough to cover all aspects of religion that the study might encounter, while on the other hand using one that is so loose that it becomes difficult to know what is being referred to when the word ‘religion’ is used (Connolly 1999). Once it was easier to point to what was considered ‘religious’ as England was deemed to be a Christian country, and the only way people could express their diverse religiosity was to join a denomination other than the dominant state endorsed Church of England. Pagan practices and witchcraft, if present, were not alluded to. However, now the boundaries between religious and non-religious activities are less easy to distinguish. As Hamilton (2001:13) asserts, religion now comes in a ‘plurality of guises’: where once there were simply different denominations and sects now there are “new age practices, flying saucer cults, radical environmentalism, eco-feminism, human potential groups, and holistic therapies”. Some people have even included sport and dietary practices as a form of religion, but Stark and Bainbridge objected to “lumping supernatural and naturalistic faiths under the common term religion”, as they felt that they were totally different systems of thought (1985).

Although no sociologist has provided a definition that is acceptable to all, most can be divided into two main perspectives: ‘substantive’ - what it is - or ‘functional’ - what it does (Davie 1999). Substantive definitions focus on the beliefs and practices of a religion and assume that supernatural beings exist, whereas functional approaches look
at the effect on society of the religion rather than its belief system. Both approaches have advantages and disadvantages, but the main issues centred on the importance of beliefs and practice.

### 2.7.1 Substantive Definitions

Substantive definitions limit their field to belief systems that acknowledge the existence of supernatural beings or entities. Davie found using such a classification helpful because the boundaries between what was religious and what was not were more easily defined, although she noted that notions of the supernatural differ in western and eastern cultures (1999). One early substantive definition often quoted in the literature was Tylor’s description of religion as “belief in Spiritual Beings” (1958 [1871]), as it expressed the presence of spiritual entities. However, it was criticised for being too intellectual, and for its failure to make reference to religious emotions such as awe and reverence in relation to religious beliefs. Others felt that he implied that the ‘beings’ were too personal, whereas anthropological evidence showed that spiritual entities were more likely to be conceived as impersonal powers (Scharf 1970).

However, Connolly (1998) approved of Tylor’s definition as it contained the element of ‘spirit’, which he felt was essential for distinguishing religion from other areas of human experience and behaviour. Other ways he described this spiritual element were divine, holy, numinous, sacred and supernatural. Connolly defined religions as “any beliefs which involve the acceptance of a sacred, trans-empirical realm and any behaviours designed to affect a person’s relationship with that realm” (1998:181). He felt that they referred to a trans-empirical realm which is believed to be accessible to human beings and deemed to be the primary source of fulfilment for them. Unlike Durkheim he thought religions could be both communal and individual.

McGuire (1987:6) found that the three elements in Spiro’s definition to be sociologically relevant: ‘institution’, ‘culturally patterned’, and culturally postulated’:

...an institution consisting of culturally patterned interaction with culturally postulated superhuman beings. (Spiro 1966:98)

Although all ‘institutions’ have socially shared patterns of behaviour and beliefs which are culturally specific, the difference with religious ones is the acknowledgment of the presence of ‘superhuman beings’ which emphasized the sense of power. However, other researchers found that the term ‘superhuman’ did not indicate the notion of the ‘supernatural’, and could equally refer to ghosts and Santa Claus rather than gods.
McGuire (1987) felt that substantive definitions were more specific than functional ones, making it easier to identify if a phenomenon were religious or not which facilitated empirical studies of religion. She felt that they related more to the commonsense notions of religion. However, they were mostly culturally and historically bound and correlated mainly with western religions, in particular Christianity, and did not always account for non-western phenomena. Sociologists that associate religion with church-orientated activities that worship a deity exclude many eastern belief systems. Substantive definitions of religion would therefore exclude two ancient oriental religions, Confucianism and Buddhism, which have no notion of a god but reverence holy men, and have many rituals worshiping nature and ancestors.

Three types of religious belief systems can be subsumed under the substantive headings: conventional religion, common religion, and customary religion.

**Conventional religion** is the most visible form of religion in that it has an institutional structure and a belief system that has a transcendent being. Towler included Christianity, Judaism, Islam and Hinduism under this heading when he defined this type of religious category as one that included all the “principal religions of the world and their long established sub-divisions” (Towler 1984:4)

As well as the established institutions of the Church of England and the Roman Catholic Church, conventional religion in this research includes the many ‘sub-divisions’ of orthodox Christianity: independent Free Churches – the Baptist Church, the Methodist Church, the United Reform Church, Pentecostal Churches, the Brethren Meeting, and Evangelical Free Churches. It also includes Hinduism and the Jehovah’s Witnesses, but not Spiritualism which would be identified as common religion.

**Common religion** in Davie’s view was closely tied to “privatized religion” (1994:75) which she saw as the most prevailing form of religiosity of the present day in Western Europe. For religion has become a matter of personal choice, with the understanding that unless the expression of it offends other people anything can be believed. However, Davie preferred the term ‘common religion’ because it acknowledged that all beliefs, no matter how unorthodox their form and content, were not self-generated but were moulded by the culture in which the individual had been socialised.

Although Davie saw no great distinction between orthodox religion and more diverse beliefs but rather a continuum, Towler noted more of a contrast when he defined common religion as “those beliefs and practices of an overtly religious nature which are
not under the domination of a prevailing religious institution” (Towler 1974:148). He argued that common religion pre-dated conventional religion but the Church had appropriated some of its symbols and festivals. Much of today’s common religion contains the beliefs and practices that were not adopted by conventional religion, such as spiritualism, fortune-telling, astrology and superstitions. Towler suggested that the reason that people turn to common religion is that the conventional religious institutions do not always provide the support and comfort that they need particularly at times of crises such as birth, marriage, sickness and death. Common religion fills the gaps and provides the longed for reassurance and security.

**Customary religion** was a distinctive form of religion proposed by Hornsby-Smith (1991) and his colleagues to encompass the variety of beliefs that had some relation to the teachings of the Christian Church, particularly the Roman Catholic Church, as opposed to the more inclusive common religion which he argued was more akin to magic and superstition. He defined customary religion as:

...derived from ‘official’ religion but without being under its continuing control...the beliefs and practices that make up customary religion are the product of formal religious socialisation but subject to trivialisation, conventionality, apathy, convenience and self-interest. (Hornsby-Smith 1991:90)

Customary religion relates to the religiosity of many people who subscribe to traditional Christian beliefs but do not attend Church in any regular fashion. Davie (1994:94) ascribed the notion of ‘believing without belonging’ to this group of people whom she saw as making up the majority of people in England. The fact that they do not attend Church on a regular basis and therefore receive little on-going socialization within the Christian faith allows customary religion to take the place of conventional religion.

Substantive definitions have the advantage that they contain a ‘common sense’ view of religion and are amenable to empirical studies of religion. The outward form of religious activity can be measured by statistics such as attendance at places of worship, or participation in rites of passage but that is only a small part of religious life. A further criticism of substantive definitions is that being historically and culturally based, they have difficulty with religious concepts and forms that change and evolve with the passage of time.

Some sociologists see many New Age practices and forms of ritualistic worship that do not involve a deity as religious, and must use definitions that encompass a broader concept of the term religion. Some theorists have therefore looked to a functional
perspective to understand what function religion performs in peoples' lives.

2.7.2 Functional Definitions

Functional definitions look at the purposes that religion serves in society and for individuals and are much broader than substantive definitions. They would include phenomena that substantivists would exclude such as: "ideologies, ethos, value systems, worldviews, interpersonal relations, leisure activities, and voluntary associations" (McGuire 1987:9). The content of belief systems and their practices are less important than their function. Geertz offers a functional definition when he stated that religion is:

...a system of symbols which acts to establish powerful, pervasive, and long-lasting moods and motivations in men by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and motivations seem uniquely realistic. (Geertz 1966:4)

He pointed out that his definition would include golf, because people play the game with passion and ascribe symbolic meaning to it. In Japan, golf has taken the form of a religion. A minister in the Church of Perfect Liberty explained that golf is:

...a little miniature of life. We can learn about ourselves through golf. Our teachings say that in life, anger, worry, and sorrow destroy success, just as in golf. Like golfing, life is an individual game, where you seek individuality; in golf, as in life, it's always the next shot, another chance for perfection. (New York Times 1975)

Sociologists who favour a functional approach criticise substantive classifications that define religion by the presence of the supernatural beings, because it excludes some ideologies or activities that they would describe as religious. Davie (1999) reasoned that ideologies such as ecological or green movements which dealt with existential problems of life could be considered religious, despite excluding the realm of the supernatural. Even some forms of nationalism, which excluded any reference to other worlds could, she proposed, be defined as religious because they provided "collective frames of meaning and powerful inspiration for the population involved" (1999:279). However, she made the point that once what she termed the 'gold standard' of religion, namely the supernatural, had been removed from the understanding of what makes an activity or belief system religious, it is very difficult to decide what can or cannot be included in the classification.

Functional definitions are characterised by their inclusiveness. Yinger saw religion as "a system of beliefs and practices by means of which a group of people struggles with the
ultimate problems of life” (1970:7). Hamilton agreed with Davie that such definitions were too broad, as he reasoned that this could include belief systems and ideologies such as communism, which were clearly anti-religious, and the term ‘ultimate problems of life’ was open to interpretation by each individual. Campbell (1971) pointed out that what constituted a ‘problem’ in society was learnt, and could vary within different cultures. As most cultures contain some form of religious conceptions, any learning will inevitably be shaped in part by religious notions of what constitute ‘ultimate problems’. The argument can become circular, as the term ‘ultimate’ is usually defined in religious terms.

Durkheim included beliefs and practices in his functional definition, and drew a distinction between the sacred and the profane. He defined religion as:

...a unified system of beliefs and practices relative to sacred things, that is to say, set apart and forbidden – beliefs and practices which unite into one single moral community called a Church all those who adhere to them. (Durkheim 1995/1912:44)

For him the sacred, which was ‘set apart and forbidden’, had to be approached with caution through ritual, as its power could be dangerous as well as beneficial. The concept of the sacred was very broad and could be applied to human beings, animals, to inanimate objects, or to abstract ideas and beliefs. Durkheim said that man ‘superimposes’ sacredness, so nothing was intrinsically sacred. Goode agreed with him, and pointed out that ‘no object, phenomenon, or experience is intrinsically sacred. It is rather by virtue of the relationship of the object to the society that it is imbued with sacredness, made symbolic and charged with meaning’ (1951:45).

However, Hamilton disagreed with Durkheim’s view that what is sacred in religion is a universal conception. He felt that the terms ‘sacred’ and ‘supernatural’ were culturally bound, and that they fit better with the western traditions of their authors rather than with non-Western societies (2001). What is sacred is therefore not self-evident but is socially defined, or may even be personally construed. In this present research, which dealt with the mentally ill, an openness of mind was essential to acknowledge what was sacred to each individual, so that no value-laden boundaries were ascribed to their religious experience.

Much of religion is involved with dealing with the unknown and uncontrollable parts of existence. Durkheim’s definition reflected the structural element in religion when he pointed out that a social group of believers are united by beliefs and practices. Most
Religions maintain a mythic explanation of the meaning of society and its structure within a universal setting. They offer explanations for common experiences such as creation, birth, death and hardships, and transform the individual’s experience into a generalised experience of the whole of creation which gives meaning to existence. Ritualistic activities, performed alone or in a group, serve to reinforce the myth and are part of many religions.

Hargrove (1979) felt that religion was used to explain or understand phenomena and forces that culture could not give meaning to. The most inexplicable of all experiences was death. In most cultures religious rituals and beliefs were used to cope with the ultimate lack of control at the end of life. She used a functional definition to obtain a sociological understanding of religion.

Religion is a human phenomenon that functions to unite cultural, social, and personality systems into a meaningful whole. Its components generally include a community of believers who share a common myth that interprets the abstractions of cultural values into historic reality through ritual behaviour, which makes possible personal participation in a dimension of experience recognised as encompassing something more than everyday reality – the holy. These elements are united into change, development and deterioration. (Hargrove 1979:12)

2.8 Religious Experience

In the same way that it was important to define religion, before looking at ‘religious experiences’ it is necessary to describe exactly what is meant by the term. Again, as with religion, different researchers have studied different aspects of this multifaceted concept and sometimes have noted opposing views about the nature, cause and consequence of religious experiences. People in other disciplines such as psychologists, socio-psychologists, neurologists and anthropologists have done much of the work on the subject. However, as this is a sociological study the prime consideration is the social relevance of religious experience, both in the external way it relates to society and the individual way it impacts within the person.

Religious experience was for Batson and Ventis simply “religion as experienced by individuals, not in a self-contained set of beliefs or an institution in society” (1982:4). They argued that of all the creatures that inhabit this earth only human beings were aware of their existence in this world, and that the present life was finite. Again, it was only humans that were able to contemplate the existence of other worlds. This in turn led to existential questions like: ‘what is the purpose and meaning of life’; ‘what will happen to me when I die’; ‘is there life after death’; ‘is there a God’? Batson and Ventis
believed that it was religion that answered such questions. Many questions could be important in a person’s life, but only those that concerned the nature of life itself could be considered religious in nature. They wanted their definition to cover, not just areas usually associated with religion, such as belief in a god and an afterlife, worship, prayer, ritual, and mystical or conversion experiences, but also non-tradition varieties of religious experience, such as:

...belief in some impersonal cosmic force, focus on self-actualization in this life, participation in self-help or social-action rituals, even the experience of being converted away from one’s religious heritage into the sense of personal freedom and responsibility that can accompany living without any gods. (Batson and Ventis 1982:9)

Batson and Ventis differed from Yinger in that they did not want to look to beliefs and practices alone to answer the questions about life, but to religious experiences as well. They also wanted to look at the understandings of individuals not just those of groups. A religious view would differ from a philosophical one, in that for a religious person existential issues would be dealt with on an intensely personal basis and the answers could have life changing consequences, whereas for a philosopher they may be impersonal, abstract and universal problems.

Despite the fact that many people view their religious beliefs and understandings as freely arrived at and made through personal choice, most social scientists would not agree. Religious experiences are influenced by the individual’s social background, life’s experience and social environment. The theory of ‘social influence’ proposes that ‘what we as individuals think, feel, and experience is strongly influenced by other people’ (Batson and Ventis 1982:28).

In many ways religious experiences are no different from other experiences. Erving Goffman (1971) compared social life to a stage play in order to express the indirect social pressures that influence people’s lives. Using the theory of social influence and taking the analogy of a play, where people in a theatrical production play parts, read from scripts, and perform in front of an audience so in real life they have ‘social roles’, ‘social norms’ and ‘reference groups’. The social roles can be defined as “behaviour patterns that are characteristic, and expected, of a person or persons who occupy some position in a social structure” (Batson and Ventis 1982:30). All people have several identities or social roles; for instance a woman can be a daughter, wife, mother, doctor, Anglican, musician, which are entered into depending on the social setting. The role they play is governed by social norms which are “a group’s unwritten rules of
appropriate behaviour for those occupying particular roles” (Batson and Ventis 1982:31). Each social role will have its own norms, and tension can be caused if the expectations of two different roles are in opposition to each other. The mother of a small child might want and be expected to be at home to look after it, whereas in her professional role she would have to be at work. The friction caused when two roles conflict shows the existence and power of roles and norms. People do not live in isolation. From birth they are molded and influenced by the people they come into contact with; these act as ‘reference groups’. A reference group is ‘any group whose judgment an individual values’ (Batson and Ventis 1982:31). They stipulate the group norms and act as judge on the individual’s actions. It is the fact that the individual wants their approval that ensures conformity to the expectation of the group, just as actors look to an audience to judge how good their performance has been and to seek applause. The religious beliefs are likely to be influenced initially by the social norms of the family. Later they will be tempered and maybe altered by other reference groups. Even the manifestation and description of religious experiences will conform to the norms of the group, even if they are expressed in different ways when acting in different roles.

Meredith McGuire (1987) saw religious experiences as being firmly rooted in the individual’s cultural milieu, with interpretation of their meaning given through socially determined symbols. She defined religious experience as “all of the individual’s subjective involvement with the sacred” (1987:15). They could vary from a moving conversion experience or an awareness of the presence of God to a powerful experience during a religious ritual. The experiences were private but people express them socially, either in conversation or in communal religious rituals. She felt that all experiences, even private ones, had a social element because it was the socially learnt beliefs that shaped the interpretation of the experience.

Religious experiences differ in their intensity from fleeting feelings of serenity and wonder to life-changing mystical experiences. Different religions encourage different forms and levels of experience. Within the Christian denominations most do not encourage strong emotional experiences, except in the Pentecostal churches where they are sought after and considered to be a normal part of religious practice. Individuals within cultures and groups that encourage such experiences are more likely to undergo religious experiences than those from traditions that neither seek for nor recognize such occurrences. McGuire found the American culture in general did not value spiritual experiences, despite the fact that many Americans had experienced one. She felt that
this was due to their preference for “rational, intellectual, objective, ways of knowing” whereas religious experience was “a way of knowing by subjectively apprehending a reality” (1987:17). A person expressing a deep sense of peace from feeling the presence of God may be valued within a group that held such a sensation to be a theologically sound possibility, whereas people outside the assembly would interpret the experience in different ways from scepticism to scorn.

The substance of religious experiences can vary from agreeable feelings of peace, safety, well-being, happiness, contentment, and fulfillment to unpleasant ones of fear, terror and pain. The experiences relate to the sense of power that the group ascribe to the element that is held to be sacred. The individual can experience warm feelings of security and peace if the power protects from harm. Conversely, feelings of terror and danger can be felt if the sacred is seen to cause harm to the individual. These experiences can easily affect the whole group, and become a group experience of the power of the deity or force that they hold as sacred. Belonging to a group of like-minded believers can help to foster religious experiences. Rituals and shared group experiences can promote a sense of belonging and togetherness with others.

Experiences can be overwhelming. Some can produce an ‘alternative state of consciousness’ in which the person feels cut off from everyday reality (McGuire 1987:16). These experiences can be drug induced, so it is the symbolism (the meaning attached to them) and the context in which they occur that determines whether they are regarded as religious in nature.

Sociologically, religious experience is understandable if it results in social action. If there is a change in a person’s life or social actions it is possible to understand and measure what the experience meant for the individual. Abukuma (1999) felt that sociological understanding comes from a combination of social action and the subjective meaning of the experience. St Paul’s conversion was an example of an intense religious experience leading to an altered lifestyle. He changed from persecuting the Christians to being a passionate follower of Jesus himself (Acts 9:3-9). It can be assumed that there was a relationship between his experience and his change of social action. Max Weber interpreted the subjective meaning of his conversion experience.

Paul’s conversion was not merely a vision in the sense of hallucinatory perception. Rather, his conversion was also recognition of the profound inner relationship between the personal fate of the resurrected founder of Christianity and the cultic ideologies of the general oriental saviour doctrines and conceptions of salvation. (Weber 1963:130)
Benson and Ventis felt that religious experiences, as indeed all experiences, left ‘tracks’ such as changes in beliefs and behaviour, reports of experiences, and changes of mood, that are observable to the outsider. It is these tracks that can be used by the researcher to investigate the phenomenon, but it is important to differentiate between the experience itself and the social action that follows it. The behavioural consequences of religious experience are like the symptoms of a disease: a skin rash can point to an illness but it is not the illness itself. However, it is important when analysing the nature and function of the religious experience to be circumspect in taking at face value every experience that is offered as religious: a person could relate a fabricated experience, or find difficulty relating abstract feelings.

Yamane (2000:173) argued that sociologists cannot study religious ‘experiencing’ empirically as it is takes place within the individual, but rely instead on accounts of experiences. However, expression of the content of an experience is always referring to a past event. It is not possible to experience and reflect on an experience at the same time, so that all accounts are retrospective. When the experience may have taken place a long time in the past the reflection on the experience can be imprecise. Yamane contended that sociologists:

...must bracket any claim to apprehending religious experience in itself and instead give our full attention to the primary way people concretize, make sense of, and convey their experiences: through language, and in particular through narratives. (Yamane 2000:4)

It is therefore understanding how people make religious experiences meaningful and then how they convey that meaning that is of interest to the sociologist.

2.9 Conclusions

Within this chapter I have sought to position this research that looked at the religious experience of a sample of people with enduring mental health problems at the beginning of the third millennium, and to review the concepts of ‘mental illness’, ‘religion’, and ‘religious experience’.

Both mental illness and religion are not value free concepts but are complex areas deeply enmeshed in culture and socialisation. I have looked at the history and care of the mentally ill in England because the sample was predominantly English, and to understand their religious and mental frameworks it was important to focus on their particular culture. The care of the mentally ill today has evolved over many centuries but has at its roots many Christian understandings that would not be present in all
cultures. For example, the notion that there is a duty to care for the sick - in historical times it was the religious, often nuns, who took on this role. Also there is a fundamental belief that God personifies goodness and the Devil badness, unlike some cultures where devil and spirit worship is normative.

Many of the respondents in this present research had been brought up in religious families, had attended a Sunday School in childhood, or had learnt the Biblical stories in school and therefore had been made aware that in some Christian theology mental illness can be caused by demon possession. It was a theme that had been evident in the historical views of mental illness and was deeply entrenched in the socialisation of English society, and unlike some societies where demon possession bestowed wisdom and power it had only negative connotations. It was little wonder that the service users in my sample had a higher than average belief in the Devil and hell, and religion for most was not spoken about.

This study deals with the relevance of religion in the lives of mentally ill people. Having grown up in Britain most of those investigated had been socialised within a Christian religious framework with a residual Protestantism, because as Davie argued, in Britain “Christian nominalism remains a more prevalent phenomenon than secularism” (1994:76). Despite Connolly’s (1999) warning not to draw the boundaries too tightly when defining religion, because nominal Christianity was fundamental to most of the sample, I preferred to use a substantive definition of religion, agreeing with Davie that using a classification that limits religion to belief systems that recognise supernatural beings facilitates demarcation of what can be termed religious. I did not want to include leisure activities, new age practices and esoteric ecological worldviews, although this was not conveyed to the respondents. Although I was interested in the function that religion played in their lives, a substantive definition was required and I found Connolly’s substantive definition of religion fitting:

...any beliefs which involve the acceptance of a sacred, trans-empirical realm and any behaviours designed to affect a person’s relationship with that realm. (Connolly 1998:181)

It was not prescriptive, and it took note of a ‘sacred otherworld’ that was not part of everyday life.

It was also necessary to have a broad concept of ‘religious experience’ in order to accept as religious whatever the respondents chose to identify as such. Therefore, within this study a wide definition was formulated, although it was not presented to the sample,
so that they could decide for themselves their interpretation of the concept. I formulated the definition of religious experience as:

Any experience that is out of the ordinary, to which a religious interpretation is given by the person who undergoes the experience.

As has been noted, within the psychiatric system in England the medical model is used by psychiatrists when treating service users. This informed the definition that I used to define enduring mental illness, which for this study will be defined as:

A psychiatric condition that has been diagnosed by a psychiatrist according to the Diagnostic and Statistical Manual of Mental Disorders, which will be a recurring feature of the service user's life requiring treatment.

Having positioned the research and looked at the concepts concerned, the next chapter will review the literature that was relevant to the research.
Chapter 3

The Religious Experience of the Mentally Ill:  
Previous Research

3.1 Introduction
At the commencement of this research very little research had investigated the religious lives of the mentally ill (Larson, et al. 1986). A few studies had been undertaken to analyse different aspects of religion in the lives of psychiatric patients but most simply looked at denominational affiliation, church attendance, or at psychological variables of religion. Much of the literature comes from studies undertaken in the United States whose society, history, culture and religiosity are very different from our own. Therefore findings from North America may not be able to be extrapolated to an English population.

3.2 Relationship between Religion and Psychiatry
One of the few studies to look at the relationship between mental illness and religion was undertaken by Rodney Stark (1971).

He dismissed the view that there is a positive association between religious commitment and psychopathology on theoretical and logical grounds. Although researchers had looked at the lives of some saints, mystics and founders of religions and found them to have deep-seated psychopathologies, he argued that this would not prove that all religious people were mentally ill. Indeed, he questioned why people should accept their revelations and religious experiences as real and follow them if their behaviour was in fact dysfunctional. He found fault with those that claimed a high incidence of ‘religious imagery and preoccupations’ in people with psychosis in mental asylums, arguing that they did not make a comparison with the number of religious people who did not suffer from a mental illness. He would expect to find religious people with mental illness in a society where religious commitment was normal practice, so that it would be illogical to consider that it was religion that had caused the psychopathology. He added further that “pathological conditions logically cannot account for the predominant behaviour of stable social groups” (Stark 1971:166). If normative religious commitment in the
society were explained by an underlying pathological condition then 'pathological' and 'normal' would have no meaning, as 'abnormality' and 'pathology' are defined as deviation from the group norm.

Stark distinguished between 'conventional religious commitment' which he found common in the United States in the 1970s and 'pathological commitment' with extreme and unusual features – morbid fears, obsessions with holiness, eccentric revelations. In his San Mateo Study he compared 100 randomly selected patients from a mental health clinic with 100 people from the same community. Included in the survey were questions on religious commitment; affiliation, importance of religion; belonging to a church congregation; church attendance. On all the measures of commitment he found people diagnosed as mentally ill were significantly less committed than those from the general population, which supported his hypothesis that religious commitment and mental illness were negatively related. To test if religious commitment was stronger in those less incapacitated by their psychopathology, i.e. those who would not be found in a hospital, he used items from a national survey to measure 'psychic inadequacy'. He proposed that agreement with such statements as 'I worry a lot', 'I often feel quite lonely', 'I tend to go to pieces in a crisis' were a reasonable indicator that a person was unable to cope with others and life in general. People who agreed with three or more of his five items were classified as 'high' on 'psychic inadequacy'. He found that people who scored high on 'psychic inadequacy' were less likely to turn to orthodox religion for comfort. Although he admitted that his study did not prove whether psychological health is the product or source of religious commitment, he argued that finding that there was no association between religion and psychopathology meant that it was not possible to argue that one caused the other.

In 1971 Stark found the research into religion and psychopathology to have been 'scarce, dated, and usually very inferior', with no control groups, incomplete methods and inappropriate samples (1971:167). Several of the studies used religious professionals in the form of seminarians or nuns as their sample who would differ from the general population in demographics such as age, social class, education, and religious affiliation. As he pointed out the finding from professionals would probably not be applicable to the laity. The only reliable study he found concluded that there was a positive correlation between good psychological adjustment and religious commitment.

The same problem that concerned Stark when assessing the usefulness of studies in
which the sample he used were non-representative of the society he was looking at, may be true when extrapolating his findings from US studies to the United Kingdom with a less religious society. Unfortunately, most studies have been conducted in the US and their relevance to the United Kingdom will be assessed later.

More than a decade after Stark’s study Larson et al found that “academic knowledge and skills needed to evaluate religion have not been absorbed into the psychiatric domain” (1986:329). In looking at 2,348 psychiatric articles found in four psychiatric journals between 1978 and 1982 only fifty-nine had included a quantified religious variable. Thirty-seven used denomination, seventeen used religious commitment, and five used both. Under 1% used religious commitment. Larson (1991) compared other systematic reviews of sociology and psychology literature and found that when measuring religious commitment, both sociologists and psychologists used multiple measures more often than psychiatrists did.

Lukoff et al (1992) found that mental health professionals tended to ignore or pathologise the religious and spiritual dimensions of life in theory, research and practice. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-111-R), which was used by psychiatrists to diagnose mental illness when this article was written, religion was consistently negatively portrayed. All twelve references to religion in the Glossary of Technical Terms were used to illustrate psychopathology (mental illness).

Religion and religious beliefs have been major determinants of human behaviour since the dawn of time. Burhoe (quoted in Heftier 1997) felt that science had destabilised traditional religious frameworks of meaning that were essential for any wholesome society. He saw that the same evolutionary processes underlying the natural world produced religion, to save society from the anomie and destruction that come from scientific explanations that lack values that make for survival.

Although the role of religion in health-related behaviour has often been recognised, most health studies have looked no further into religious behaviour than to classify subjects by religious affiliation. Sims (1994) felt that psychiatrists excluded the spiritual component when trying to understand their patients, and only asked to which religions they subscribed, rather than what their religion and faith meant to them.

Most studies only measured denominational affiliation rather than using such variables as religious commitment, belief, attitudes or practice (Larson, et al. 1986). Kroll (1998)
as cross-cultural psychiatry had become a factor in the past two decades as the impact of world-wide migration brought new expressions of mental illness into their practice.

Throughout the ages there have been opposing views as to the efficacy of providing spiritual succour for those suffering with mental illness. With the dissolution of the monasteries care of the mentally ill became the province of the medical profession and a differentiation was made between the physical, mental and spiritual aspects of the person. Although there is now a recognition of the need to treat the whole patient, most professionals remain in their own speciality and seldom communicate with each other across disciplines.

However in 1997 research by the Mental Health Foundation in the UK found that over 50% of their sample of people with enduring mental illness expressed ‘religious needs and interests’ (McKerrow and Faulkner 1997). Service users were at last asked what they wanted from all the different bodies offering them treatment. Many found the alternative medicines and practices more appealing than the medications provided by the psychiatrists, and found help through religion and spiritual activities. It found that religious or spiritual beliefs played a part in the lives of 223 people, just over half the people surveyed. 31% referred to Christian beliefs of one kind or another, mainly in general terms rather than to a specific church or denomination. The second largest group was of people who referred to a belief in God or described activities such as prayer but again gave no reference to a particular church or denomination. A higher proportion of African-Caribbean people affirmed a religious or spiritual belief (predominantly Christian) than either the white people or people of other ethnic groups. In their sample there was no difference by gender or age. A belief in God, a sense of meaning, prayer, Bible reading and the support of religious friends were most valued. However, a small minority reported having found certain aspects of the Christian faith, or churches or people within them harmful, especially when they fostered guilt about illness as a sign of inadequate faith.

A mismatch has been noted between the levels of religiosity of mental health professional and the patients whom they treat. Needleman and King (1993) in the UK found that mental health professionals were less religious than the average person in the population and uncertain how best to respond to the spiritual needs of their patients. They know that religion is important to some people in their care but are fearful of saying and doing something wrong and inflaming a person’s illness by encouraging religiosity.

47
Roskes, Dixon and Lehman (1998) in the US recognised that historically psychiatrists have viewed religion 'as a secondary derivative of structural psychic process' and therefore unimportant from a clinical standpoint. Religious issues were thus largely ignored in psychiatric research, leading to a cadre of practising psychiatrists who were uninformed regarding these issues. This in turn led back in a recursive process, as new psychiatrists were led to conclude that religion was indeed unimportant clinically (Sims 1994).

Connolly (1998) commented that psychologists, as distinct from psychiatrists, in the United States have consistently been shown to be the least religious of all types of scientist. He found that, for many, religion promotes negative self-evaluations, emotional repression, anxiety, dependency, conformity and a whole host of other debilitations.

Surveys conducted in the United States consistently show a 'religiosity gap' between clinicians and patients. Both the general public and psychiatric patients report themselves as being more religious and to attend church more frequently than mental health professionals. In a survey in 1975 by the APA Task Force on Religion and Psychiatry 50% of the psychiatrists described themselves as agnostic or atheists, and in a 1980 survey 57% of psychologists the same. This contrasted with between 1% and 5% of the general population. A Gallup Survey in 1985 found one third of the population considered religion to be the most important dimension of their lives and another one third very important. Kroll and Sheehan (1989) in the US found that religious beliefs and practices also assumed an important and often central place in the lives of psychiatrically hospitalized patients.

Bergin’s (1990) survey of psychiatrists, psychologists, social workers, and marriage and family counsellors found that 68% endorsed the item indicating that they “seek a spiritual understanding of the universe and one’s place in it”.

Despite the importance of religion and spirituality in most patients' lives, neither psychiatrists nor psychologists are given training to prepare them to deal with religious issues. Post (1990) noted that “few psychiatrists are trained to understand religion, much less treat it”.

However, in the United States a number of religious psychiatrists actively promote new approaches to psychotherapy based on conventional religious commitment. A survey
that these psychiatrists believed that prayer and the Bible could be used effectively to help patients deal with grief reactions, suicidal intent, sociopathy, and alcoholism. However, for acute schizophrenic or manic episodes, the respondents considered psychotropic medication the most effective treatment. The respondents were somewhat more religious than Americans overall, who are themselves more religious than most psychiatrists. This group of religious psychiatrists is the exception, and while the population appear to give religion a major place in their lives mental health professionals on the whole do not.

Most studies have been executed in America and it is difficult to know how much they can be generalised to the United Kingdom. One of the most helpful articles therefore was written by Needleman and King (1993) because they researched an English sample. They looked at 231 psychiatrists working in London teaching hospitals to investigate their private religious attitudes and how these affected their reported clinical practice. Only 27% reported a religious affiliation and 23% a belief in God.

Each doctor was given a semi-structured questionnaire with a multiple-choice format and space for further comment. Four areas were explored: the role of religious belief in mental illness; the relevance of patients' religious and spiritual beliefs in the doctors' clinical practice; the psychiatrist's religious background and beliefs and that of his or her family of origin; and the role of the psychiatrist's personal beliefs. There was a marked dissociation between the psychiatrist's own religious beliefs and those of their parents. Those trained outside Europe were more likely to believe in God, but there were no associations between age or clinical seniority and reported religious beliefs and practices. It may be difficult to compare these figures with the United States where 50% described themselves as agnostic or atheistic because the categories are different. Needleman and King found that 92% of their psychiatrists considered that there were links between religion and mental illness, and 92% felt that psychiatrists should concern themselves with the religious beliefs of their patients during assessment and therapy. However, there was no consistency in their views about the association between religion and mental illness: 78% considered that religion was a possible way to sublimate psychological problems; 74% that mental illness may intensify religious belief; 61% that religion may protect from mental illness; 52% that mental illness may reduce religious belief; 42% that religion may lead to mental ill health.

Respondents indicated that they often asked patients about their religious beliefs and suggested referral for religious or spiritual help, but religious leaders were not generally
considered as agencies to whom direct referral by the doctor should be made. Most considered that it was up to the patient to initiate contact.

Needleman felt that a similar pattern of discrepancy between patients' and psychiatrists' religious beliefs may exist in Great Britain as in the United States. They compare the findings from several reports that show 90% of the US population state that they believe in God but only 40-70% of psychiatrists, whereas in Britain 80% of the population state that they believe in God compared with 23% of his sample of psychiatrists. In contrast, although the doctors were less likely to believe in God than the general population they were more likely than the general population to have been brought up in religious homes – 43% had a traditional religious affiliation compared to 21% for the general population.

He concluded that there was no evidence that psychiatrists' personal religious beliefs lead to idiosyncratic clinical practice, but psychiatrists are undecided about the role of religious or spiritual belief in the development of, or recovery from mental illness and are reluctant to liaise directly with the clergy or other religious leaders.

However, there is evidence of a rapprochement being brokered in some areas, with examples of both professions acknowledging the problems of the past and working together for the betterment of service provision for the mentally ill. This can sometimes be seen as a direct result of user empowerment (Foskett 1999). Sufferers from mental illness are beginning to have more of a voice in the treatment they receive at the hands of those that society deems should take control of their lives. One NHS Trust in Somerset listened to their service users and members of the 'survivor movements' who demanded that the mental health professionals and the clergy work together, to provide a comprehensive service which respects and includes religious and spiritual resources (Foskett 1999).

The former Anglican Archbishop of Canterbury, George Carey, in his address to the Joint Conference of the Royal College of Psychiatrists and the Association of European Psychiatrists (1997) said that professional rivalry had been a cause of friction and antipathy between religion and psychiatry. Some clergy have resented the way in which their parishioners now turn to counsellors and psychiatrists when they might have come to them in the past. Moreover they have been saddened and angered by the fact that some of those so consulted seem to have been prepared to take no account of the religious or spiritual realities which, in their view, are fundamental to a proper understanding of the human condition. Psychiatrists, on the other hand, have rightly
despaired at times at the blundering efforts of some priests and ministers who have 'invoked a hot line to the Holy Spirit' to deal with all kinds of mental illnesses.

Estimates of the use of mental health services indicate that on an annual basis, of the 15-20% of the US population suffering from mental disorder, only 21% see mental health professionals (psychiatrists, psychologists, psychiatric nurses, and social workers). 54% use the primary-care sector, 3% general hospitals and 22% see clergy and other non-medical therapists and therapy groups. According to Aist (1987) in the United States clergy outnumber psychiatrists by nearly ten to one and are much more equitably distributed geographically than are mental health professionals.

Larson et al (1988) looked at whether people with mental health disorders sought help from mental health professionals, from clergy, or from both. The analysis focused on four groups of people with psychiatric symptoms who had sought help for problems with emotions, nerves, drugs, alcohol, or mental health at any time in their lives. The four groups were (1) those who sought help from clergy but not from outpatient mental health specialists, (2) those who sought help from out-patient mental health specialists but not clergy, (3) those who contacted both, and (4) a control group who had sought help from neither. The data provided an opportunity to explore the role of clergy in the treatment of mental illness. Many people who sought help from both clergy and mental health specialists had major, life-altering disorders, including major depression, schizophrenia, and bipolar disorder. These conditions not only severely alter a person's ability to function in everyday life but also make that person's significant others acutely aware of his or her impaired functioning. The most striking finding was that persons who had serious psychiatric disorder were just as likely to seek out clergy as to seek out mental health professionals. Those seeking help from the clergy were just as likely to have major psychiatric disorders as those seeking help from a mental health specialist. Sometimes those with severe disorders sought out both clergy and mental health professionals, but sometimes they exclusively sought help from the clergy. However, individuals with a history of alcohol or drug abuse preferred to seek out mental health specialists rather than clergy. The data therefore indicated that the clergy, with or without the help of mental health professionals cope with parishioners who have a broad spectrum of psychiatric disorders.

The only study to look at the religious needs and resources of psychiatric patients was undertaken by Fitchett, Burton and Sivan (1997) in a Midwestern state in the US. They compared fifty-one psychiatric in-patients with fifty general medical/surgical patients
who were matched for gender and age. They looked at religious beliefs, practices and religious social support.

They conceptualised 'religious needs' as "the need for strengthened religious beliefs, participation in religious rituals, or support from clergy or others" (Fitchett, et al. 1997:320). Religious resources were conceptualised as "higher levels of participation in religious practices and higher levels of religious belief" (1997:321). Using a five-point scale they asked their respondents to identify their 'religious needs': knowledge of God's presence, purpose and meaning in life, and relief from the fear of death. 'Religious practice needs' were prayer and communion, the 'religious social support needs' were a clergy visit and support from another person. They were also asked about religious needs while hospitalised and any other religious need not listed. They found both their groups similar in their reports of spiritual needs, however there was a difference in reported religious resources: the psychiatric patients had significantly lower scores on their 'religious social support needs'.

Clearly there are omissions in the literature pertaining to religion as experienced by the mentally ill, particularly in Great Britain. It appears that no one has given the users of mental health services the opportunity to express their views about different aspects of religion, and to report on how the professions dealt with their religiosity.

3.3 Religious Experience

Over the past thirty years various attempts have been made to determine the incidence of the occurrence of 'religious' or 'mystical' experiences, mostly by means of structured questions on national surveys and within specific group studies. (Argyle and Hills 2000; Greeley 1975; Hardy 1979; Hay 1979; Hay 1982; Hay and Morisy 1978; Pupynin and Brodbeck 2001; Spilka, et al. 1996; Thomas and Cooper 1978)

Alister Hardy (1979) was first drawn to the topic after reading an article in the daily press in 1925 describing a religious experience. After an abortive attempt to collect such narratives, by advertising in religious journals in England for people who had had a religious experience, he only obtained two hundred examples coming mainly from elderly females who read such publications. However, from 1969 the national press became interested in his Religious Experience Research Unit in Oxford and published articles about it, which included requests for accounts of religious experiences from the general public.

Despite expressing at length what he was seeking, the public sent him ecstatic and
dramatic examples of isolated occurrences. He felt this might be caused by the term “Religious Experience” included in the name of his Unit. He was looking for experiences “with a continuing feeling of a transcendental reality or of a divine presence” (Hardy 1979:18). He therefore decided to leave it to the public to send in what they decided had been “an experience of a religious nature”.

Qualitative studies of religious experiences are interested in description and classification of the experiences whereas quantitative studies look at measurement and causal analysis of precipitating factors. As Yamane notes (2000), the dominant qualitative approach in the study of religious experiences employs a structured question for a filter and an open-ended interview of those that give a positive reply to the filter question. The wording of the filter question is therefore of great importance. As Hornsby-Smith argues, “Reports of religious experiences are dependent on the question asked of respondents and the way it is interpreted by them” (1998:417).

When David Hay looked for a question to use in his surveys (Hay 1979; Hay and Morisy 1978) he rejected Hardy’s long enquiry as too “complex” and “incomprehensible”. He then assessed the question that Hardy printed in the religious journals when requesting religious experiences to be sent to him:

Have you ever been aware of or influenced by a presence or power, whether you call it God or not, which is different from your everyday self? (Hay 1982:111)

Hay sought for other words that would elicit the experiences that he wanted to examine but found them no better: if he asked directly about religious experiences he got two extremes from “All experience is religious” to “Certainly not! Religion is bunk!”(Hay 1982:112). Questions about ‘numinous’ or ‘mystical’ experiences were not understood, so he used Hardy’s now seminal question published in the religious journals.

In their attempt to see if social surveys could access deeply held personal views Back and Bourque used a question about religious experiences in three American surveys: “Would you say that you have ever had a religious or mystical experience, that is, a moment of sudden religious insight or awakening?” (Back and Bourque 1970). Also in the United States Greeley and Mc Cready asked their respondents: “Have you ever felt as though you were very close to a powerful spiritual force that seemed to lift you out of yourself? (Greeley 1975).

A more recent research study in England looked into religious experiences. Olga Pupynin and Simon Brodbeck asked the general public in London: “Have you ever had
an experience that you would categorise as sacred, religious, ecstatic, paranormal or mystical?" (Pupynin and Brodbeck 2001) If the answer was positive they asked the people to indicate which category was most applicable, thereby getting a better idea of what their respondents' interpretation of a religious experience might be.

Of particular interest to me was the study in Somerset (Nicholls 2002) undertaken by people who were themselves mentally ill 'service-users', investigating how 'service users/survivors' “manage their mental health problems and their religious and spiritual needs”. Although their respondents talked about their religious experiences during the taped interviews, it was solely a qualitative study and the researchers did not ask a specific question about religious experiences but only questions to “locate the interviewee in their context, their mental health and religious/spiritual history”.

The reported incidences of religious experiences appear to have increased over time. Back and Bourque included their question in three Gallup Poll surveys in the United States in 1962, 1966 and 1967, and found a steady increase in the positive answers to their question about religious experiences: 20½% in 1962, 32% in 1966 and 41% in 1967.

In Britain Hay (1982) established that 36% of the 1865 people interviewed by National Opinion Polls Ltd. said that they had “been aware of or influenced by a presence or power, whether referred to as God or not, which was different from their everyday lives”. When asked Greeley and McCready's question 31% reported having had an “ecstatic experience”, which was close to the 35% of Americans interviewed by Greeley and McCready. This was repeated in 1987 (Hay and Heald) and 48% gave positive responses.

Clearly there is a discrepancy between the percentage of people in society reporting having had a religious experience. This is dependent on the population, time and country, and importantly the phrasing of the question itself. However, across the surveys about 35% of the respondents reported having had at least one religious experience.

When Hay (1979) interviewed one hundred post-graduate students in Nottingham 65% affirmed that they had had a religious experience defined by Hardy's question. Hay and Morisy (1978) then interviewed a random sample in Nottingham when 62% related religious experiences.

It was interesting to note that Hay found when he interviewed a smaller number of
It was interesting to note that Hay found when he interviewed a smaller number of respondents, as in his Nottingham study, a much greater positive response than with the large national NOP survey. His survey response rate was similar to Greeley’s large opinion survey in the US. Other smaller interview studies or those using a written questionnaire have had much higher positive response rates than the large survey studies (Argyle and Hills 2000; Pupynin and Brodbeck 2001; Spilka, et al. 1996).

Argyle and Hills (2000) looked at the relationship between religious experiences, happiness and personality in an Oxfordshire sample of three hundred and sixty-four adults. 46% were church members and they reported twice as many experiences as the non-members, and their experiences were predominantly mild. However the ratio of mild to intense experiences was similar for both church and non-churchgoers. They found that overall 56% reported a religious experience; however, the proportion of churchgoers having a religious experience was substantially higher (75%) than non-church members (38%). Argyle and Hills reasoned that church members engage in activities that are conducive to such experiences and they may be “more inclined to recognise and accept mystical experiences as a result of their knowledge of similar events through sacred writings and religious teaching” (2000:164). They found that religious experiences were usually isolated incidences of short duration lasting for up to ten minutes, with 80% not lasting longer than a day. Only 22% of their sample reported having experiences more than several times in their lives. They noted a similarity in the nature of the experiences reported by both non-members and church members; it was the latter who accounted for all reports of repeated experiences.

Another study which looked primarily at church members was undertaken by Spilka, Ladd, McIntosh and Milmoe (1996) in the United States. The participants (142 females and 90 males) were aged between fifteen and seventy-eight years and represented twenty-six religious bodies: 67% Protestant groups; 20% Roman Catholic; the remaining 13% defined themselves as Jewish, Muslim, Native American; and “eclectic spiritual”. They were asked if “by their own definition, they felt that they had ever had a religious experience” (1996:97) and 75% affirmed that they had. This was the same proportion as in the church members in Argyle’s English sample.

The interview carried out in London (Pupynin and Brodbeck 2001) also had a high positive response: 65% based on the completed and returned questionnaires. However, they estimated that 70% or more of those they approached had in fact replied positively.

Most qualitative researchers use a classification framework to analyse the religious
collection of 3000 experiences collected between 1969 and 1979. At first he planned to
divide them into two divisions: those describing a “general sense of spiritual
awareness”, and those which were “more dramatic, ecstatic, and mystical in character”
(Hardy 1979:23). However, unlike plants he found that the experiences could not be
classified under simple headings because most were a combination of many
characteristics and indeed some could be classified under both his main headings. He
therefore categorised them into twelve main divisions and then further sub-divided them
into a total of ninety-two classifications.

3.4 Conclusions

When reviewing the literature four factors became evident:

1. There was a paucity of literature appertaining to the religious lives of people
   suffering with mental health problems.

2. Most research had been undertaken in the US which could not be extrapolated
   adequately to an English sample.

3. There existed a ‘religiosity gap’ between the mental health professionals and
   their patients.

4. Although some researchers had looked at religious experiences in the general
   population few had looked at the religious experiences of the mentally ill.

This research aimed to extend the knowledge of the religious experience of those
suffering with enduring mental health problems.
Chapter 4

The Research Process

4.1 Introduction

Initially my proposed research question sought to take further previous research which found that some patients discharged from a Victorian asylum into one English market town went to the local clergy for help when settled in the community (Fellowes 1996). I planned to investigate the interface between psychiatric patients and the churches. However, through speaking to service users that I worked with, and people who attended several churches, I became aware that few people with mental health problems actually attended church services. The contact was therefore between the service user and the clergy not with the church congregation, or even the church building. I was also aware from my contact with the clergy for the previous research that they were an extremely busy group of people, and I was reluctant to disturb them again if in fact the interface was minimal.

The literature showed that the mentally ill expressed high religious interest and needs (McKerrow and Faulkner 1997), but that little research had investigated the religious lives of the mentally ill (Larson, et al. 1986). There appeared to be little knowledge of the role that religion played in service users’ lives other than their religious affiliation, and that there was a mismatch between the levels of religiosity of the mental health professionals and their patients (Needleman and King 1993).

I therefore turned my attention away from the providers of religion and the religious institutions to the service users, and my research was redirected to investigating the religious experience of people with enduring (chronic) mental health problems. My main research question was reformulated to find out: ‘what causes people with mental health problems look to religion and what do they find there?’

Using an inductive analytic approach the research would be in two parts: Part 1 would be quantitative using an interview schedule and Part 2 would be qualitative comprising in-depth interviews.

However, had user involvement in research been in practice at the commencement of this research the focus and therefore the design of it might have been different, because my intention was to give ‘patients’ a voice by undertaking research that was rigorous.
enough to be accepted by the powerful medical professionals and academics, whom Townsend and Braithwaite (2002:117) regarded as "elitist". However, in the same way that the concept of a 'service user' had not yet emerged, so the inclusion of 'patients' in the research process had not been established; indeed it is still only in its infancy. Although my research was discussed with many service users and medical professionals, the design of the research and the implementation of all the interviews were executed by me alone. Proponents, such as Townsend and Braithwaite, of the notion that to maintain integrity all research regarding mental illness should "actively and equitably involve service users in every aspect of the research process" (2002:117), would dismiss any research not conducted by service users as lacking the understanding that only those who suffer with a mental illness could bring.

Townsend and Braithwaite would reject medical professional and academic 'outsiders' in favour of 'insider' service users when undertaking all research. However, I would argue that my insider/outsider status using an inductive empirical approach, with no painful experiences of mental illness and the mental health system, would have a more open attitude and clarity of vision to listen to service users and find meaning in their narratives. I also felt that to have allowed others to interview the respondents would have compromised the rigour of the research, and I would have missed the ethnographic details that emerged when making contact with service users. It had also to be recognised that the people I was researching suffered from enduring mental health problems and often found basic day-to-day functioning very difficult. They would not have been able to undertake the training for, let alone the sustained effort involved, in undertaking research. I suspect that it would only be the 'elite' service users who would be able to undertake research.

This chapter will describe the methodology used in the research, and discusses the rationale for using the approach.

4.1.1 Background History of the Research Population

When the Psychiatric Service was set up in the early 1970s in the South East of England it was a world leader in innovative community-based services. It was established by an eminent consultant who wanted to de-institutionalise the patients he treated in the local large Victorian mental hospital. The old asylum, built in 1905, had always been in the vanguard of treatment of the mentally ill, and the progressive ideas of the 1959 Mental Health Act were incorporated into the hospital's ethos long before its enactment. At that time most people suffering any form of mental illness, and some of those who had
broken societal norms, were treated in institutions secluded from society. Most patients occupied large wards, sleeping in large overcrowded dormitories with everything provided by the staff. Entrance into hospital brought stigma, both to the patients and their families.

In April 1957 the consultant who set up the Psychiatric Service opened a resettlement unit “to identify those patients who could, with appropriate treatment and training, live and work outside the hospital” (Welch 1993:15). It had wards in a large villa in the hospital grounds where the patients became progressively more independent; shopping, cooking and cleaning their bedrooms. To augment the work available within the hospital workshops the consultant set up a work assessment unit and graded workshops in the local town. The Psychiatric Service concentrated on getting people back into paid employment, during a period of high employment when there were local factories offering many low skilled positions with little stress. The work consisted primarily of light industrial packing and assembly work brought in from the local factories. Now such work is considered boring and an exploitation of patient labour, but then it was normal work for the local population. For the patients it was an entry into normal society with all the concomitant benefits – self-esteem, lack of stigma, acceptance by society as having a functioning role as workers.

I think it is easy to forget how societal norms have changed in so short a time. De-institutionalisation is now a fact and the old institutions have gone. What was the acceptable way of treating those suffering from mental illness – exclusion from society, has now changed after one hundred years. It is important to understand what life was like for many psychiatrically ill people until the early 1990s, because many of the service users in the Psychiatric Service in the present research experienced such a life. However, the younger people who are now being referred into the Service have a very different worldview. Many of the older generation would have left school early and had a good work history before becoming ill and being sent to the asylum. They were very keen to work their way back into a job with all the benefits that could bring. Most of the younger service users now will have been at school until sixteen years and will never have been employed. Most have taken, and are taking, illicit drugs so that many referrals read, ‘drug induced psychosis’. The factories in the town, which formally provided employment opportunities, are now closed and light assembly and packing work is considered boring and demeaning for service users, primarily because it is no longer a major employment for people in the locality.
In 1995 the male consultant retired and was replaced by a young female psychiatrist. Under her care, the Psychiatric Service changed its focus from being totally work-orientated to providing individuals with more social activities and access to ‘drop-in clubs’. This was partly as a result of the changed nature of work in the locality - from repetitive, low skilled, dull, stress-free occupations which psychiatric service users could cope with, to demanding, constantly changing, highly skilled work which can cause stress and breakdown. Whole layers of jobs in offices, which the more skilled service users could manage, have gone. Each manager used to employ a secretary whereas one person is now expected to juggle the demands of several people, and service users find this practice too demanding. As they are all now living in the community they need satisfying ways to occupy their days, and the Psychiatric Service provides help in managing their time. Whereas patients once suffered from a lack of privacy in a large institution, now many suffer isolation in lonely bed-sits.

4.1.2 Size and Profile of the Research Population

The Psychiatric Service in this present research currently treats approximately 150 service users that suffer with enduring mental health problems. Although it is constantly evolving, it is still a specialist service that takes referrals from across the whole NHS Trust. The Trust is divided into three localities with their own medical teams who treat their service users locally.

Both sexes are referred into the Service from the three localities, and are sent back to their consultant when it is felt that they are no longer benefiting from the Service. The service users are of working age 16-65 years; most are white due to the geographical location of a small market town in the South East of England; and they are diagnosed as suffering from a variety of mental illness – neuroses, psychoses, personality disorders and those recovering from substance abuse. Although the Trust cares for people with both mental illness and learning disabilities, the Service predominantly treats the former.

4.2 Negotiating Access

Before the research could commence I took note of Blaxter et al’s (1996) warning that two key issues are likely to confront a researcher: access and ethics. Mental health service users come under the category of ‘a vulnerable group’ (Dworkin 1992) and as such are protected by powerful gatekeepers and ethics committees from damaging research. Gaining access for research can therefore be very difficult. I was fortunate in
that I had been working in the field of mental health for many years, and therefore felt that I would be permitted to research the service users in the Service in which I currently worked.

To undertake any quantitative research right of entry to a sample has to be negotiated. Dworkin (1992) suggests that a researcher should learn about the system to which access is required before approaching officials in the organisation who would act as gatekeepers and award admittance. She felt that negotiating access could be easier if the researcher was an insider to the organisation and understood the politics and hierarchy of the group. Researching in a familiar workplace provides intimate knowledge and understanding of the context and working practices of the organisation, and most importantly the researcher will have a working relationship with the staff. These resources would take an outsider a long time to acquire (Robson 1993). I was fortunate in that I had access to such a sample. As a long-term staff member of the Psychiatric Service I had insider knowledge of the politics, working practices and plant. I had good working relationships with all the key staff who would ease introduction to unknown people and thus facilitate continuous access (Blaxter, et al. 1996). Blaxter et al note that a renegotiating of access, either explicitly or implicitly, takes place at every meeting.

However DePoy and Gitlin (1994) caution that insider knowledge could influence the information gathered and its interpretation, and objectivity could be compromised. I was aware that it would be easy to have preconceived ideas, and that I could be influenced by having been part of the treatment team for so long. I would know most of the service users, and those I had not treated personally I would have heard discussed by the members of staff. All working places have internal politics and I would have been part of the making of the politics, which could influence the way I undertook my research. It was important to be aware of the negative influences that being an insider could cause, but for this research I felt that the positive aspects outweighed the negative and that it would be possible to be objective in my findings.

Although ‘physical access’ may be obtained through the gatekeepers, negotiating ‘social access’ may prove more difficult (Hornsby-Smith 1993). The gatekeepers may permit a researcher to observe or question a group or individual, but unless those being researched choose to co-operate no useful data can be collected.

The negotiation of access is often a continuing process rather than a single event, and researchers have to maintain good communication and relationships for ongoing support and resources to be available when required. Although formal access may be well
instituted and the research may even have commenced, any new staff have to be informed about the nature of the study and any problems they have need to be resolved.

I found that having worked within the Psychiatric Service with the service users and staff for seven years the insider status afforded me the ease of access that would not have been forthcoming to an outsider. I also enjoyed the 'street credibility' (Robson 1993) of someone who knew how the system worked and could be trusted not to upset the service users. My professional status as a former member of staff enabled me to negotiate into the sample some service users who were originally excluded by the consultant psychiatrist, as they were happy to talk to me as someone who had worked with them for years and had established trust. I did not feel that my knowledge of the system had compromised the research because the information gathered was of a factual nature in the interview schedule and was not open to interpretation by me.

The nature of my research could be construed by some as being of a sensitive or intrusive nature which 'deals with things sacred to those being studied which they do not wish to be profaned' (Lee and Renzetti 1990). Being familiar to the Psychiatric Service facilitated the interviewing. The service users who knew me were comfortable touching sensitive issues as my role as an occupational therapist had been dealing with their problems. Those who did not know me personally were often encouraged to talk to me by both other service users and staff, who vouched for me as being empathetic and non-judgemental, and as someone who would respect their views.

However, my research had to be open to scrutiny at all times. I had to stay rigidly within the boundaries I had negotiated with the Ethics Committees and the medical staff. I could not coerce service users into participating, nor interview those that the consultant did not want me to speak to. Any covert misrepresentation of any part of my design, method, or practice could have resulted in its termination by the medical team or Medical Ethics Committee. I was aware of the process of continually negotiating access both with the staff and service users. Even access to a quiet space to interview had to be managed on each occasion.

4.2.1 Vulnerable People

Hornsby-Smith notes that "In general, it is the most vulnerable and weak groups in society, without the resources to defend themselves from inquisitive investigators, rather than powerful elites and decision-makers, who are the focus of much research
attention” (1993:62). In fact all research subjects are potentially vulnerable because they give information, or are observed, but have no control over how that information will be disseminated or used.

In this research all the subjects in the sample population had an enduring mental illness and therefore constituted a vulnerable group. Dworkin (1992) noted that for someone who is mentally ill disclosing personal information could raise fears that may be stressful. She also found that mental illness is a stigmatised condition and simply participating in a study concerning mental illness may pose a social risk.

The ability to reject coercion was diminished in the sample group for a number of reasons, making them vulnerable: their mental health reduced their ability to resist coercion (Ashley 1975); service users may have difficulty making sense of the world due to delusions or auditory or visual hallucinations; their memory may be impaired due to the fluctuating nature of some mental illnesses, or they may suffer from dementia.

There is a power imbalance between the professionals and service users in which the service users are persuaded of their need for treatment and help (Pilgrim and Rogers 1999). Pilgrim and Rogers believe that ‘An imbalance of specialised knowledge keeps the client in a state of ignorance, insecurity and vulnerability’ (1999:102). In this research the clients could feel that they were in a position of weakness, as I had the permission of the professionals responsible for their care: the consultant psychiatrist and the psychologist. Also I was identified as a professional and therefore part of the powerful elite. The other professionals who had power over them were their key workers. These members of staff have a responsibility for all aspect of the service user’s care and they too reinforced my position. Even the Technical Instructors who ran the work facilities allowed me into the workshops to interview the service users, thus empowering me.

The service users in this study were also made vulnerable by the rapid changes that had taken place in their management over the previous four years: the Victorian hospital had closed and all the patients had been resettled into the community; the NHS Trust had merged with two other trusts and changed names three times; several workshops that had been in use for twenty years had closed or been amalgamated; and the consultant psychiatrist who had created the service thirty years before and treated most patients for years had retired and been replaced by a new consultant with different working practices.
The research might have exposed the service users to psychological stress as they might feel that they had disclosed too much (Dworkin 1992), particularly as religious or spiritual issues tended to expose very personal views held about the deeply meaningful matters of life. If service users asked themselves existential questions like ‘why does God let me suffer?’, ‘what will happen to my spirit if I commit suicide?’, areas of deep pain could be touched. Research has shown that childhood sexual abuse can have a profound effect on the formation and development of an individual’s religious faith and their internalised representation of God (O'Rourke 1997). Those abused by a powerful male carer may be unable to relate to a God who is culturally portrayed in patriarchal images such as Father, Brother, Son. Interviewing service users about their religious or spiritual experiences can bring up memories of abuse and bring back feelings of vulnerability.

It was also possible that service users with deeply held religious views may have had bad past experiences when revealing spiritual thoughts within the mental health service. Those who expressed religious views may have had them dismissed especially by mental health professionals. From my experience within the Psychiatric Service I noted that many of the psychiatrists were not English, and came from different cultures with different core values, norms and religious beliefs from the majority of the service users. This may have been difficult for some service users, particularly those that held strong religious beliefs.

It would be to my advantage that, in common with most of the service users, English was my mother tongue and I would understand most colloquial expressions and cultural references that service users mentioned.

4.2.2 Informed Consent

Dworkin considered the “mentally ill a population needing special protection much like the protection awarded to children and prisoners” (1992:75). She was particularly concerned that a patient’s ability to give “consent that is truly informed and consensual” (1992:76) might be compromised when ‘cognitive ability’ is impaired by illness. Ashley (1975) felt that the mentally ill could be vulnerable to coercion so invalidating their consent. Certainly they would come into the category of subjects who would find it difficult to resist intrusion. Lidz et al (1984) found that patients often had an incomplete or wrong notion of consent, with education being found to be a predictor of understanding, but the understanding they did have often came over a period of time.
Acutely psychotic patients were able to read consent forms and declared they understood them, but objective measures did not confirm their self-reports (Irwin, et al. 1985). Taub (Dworkin 1992) felt that giving consent several times during the study helped their comprehension, and this is particularly beneficial for patients suffering cyclical illness.

The British Sociological Association suggests that informed consent “implies a responsibility on the sociologist to explain as fully as possible, and in terms meaningful to participants, what the research is about, who is undertaking it and financing it, why it is being undertaken, and how it is to be disseminated” and that it should “be obtained directly from research participants” (Hornsby-Smith 1993:63). To make consent meaningful, Dworkin (1992) says that consent forms should be at an easy reading level and in concrete language and be given in individual sessions on a one-to-one basis.

To obtain approval for my research from the Medical and University Ethics Committees they had to approve the Information Sheets that would be given to the service users before each stage of the research, and the consent forms that they would sign (Appendices 2,3,4,5). They were written taking into account the British Sociological Association guidelines and included all the relevant information about the nature of the research. In both the information sheets and the consent forms it was stated clearly that non-participation in the research would in no way affect the treatment received by the service users from the Psychiatric Service, and that they could withdraw from the study at any time.

I felt that all the service users in my sample population were able to understand the nature of the research after reading the Information Sheets and having any questions answered by me, and could give informed consent. None of them was acutely ill at the time of giving consent and there was no time lag between consent giving and being interviewed. True, they were a vulnerable group that could be coerced but I was very relaxed and did not pressurise any service user into participating. I felt that this was substantiated by the fact that some service users felt able to say that they did not want to take part, and two service users who agreed to take part in the second interview withdrew when their illness became acute. However, another service user subsequently decided he would like to take part in the recorded interview after thinking about his experience of the first interview. It was interesting that all three service users communicated their change of decision through their key worker and not directly to me. Again this reassured me that I was not abusing their vulnerability because they had
discussed their experience of being interviewed with a third party. I saw no reason to give multiple information sheets or consent forms as the research only involved at most two interviews. Giving too much information or over dramatising the research proved to cause more anxiety than making light of the whole event. I found with Dworkin (1992) that some service users very much enjoyed the attention they received during the interview.

4.2.3 Institutional Constraints
Gatekeepers have the power to permit or impede access to an organisation, a setting, or people within a setting, and they can be found at different levels in the hierarchy. Holloway and Wheeler note some of the benefits of gaining access through the gatekeepers: the researcher is enabled to “…observe the situation, talk to members in the setting, read the necessary documents and interview participants” (Holloway and Wheeler 1996).

Gatekeepers may have a different reaction to the proposed research depending on the role they fulfil within the workplace: clinical; administrative; managerial. Dworkin (1992) notes that some administrators have different attitudes towards biomedical research than to social science research and may view the latter as lower in prestige. Some gatekeepers may attempt to have control over the research and the researcher may have to ‘bargain’ with them to gain access.

An ‘insider’ in an organisation would have the benefit of knowing the individuals who act as gatekeepers and how best to approach them, although occasionally poor working relations with a colleague could hinder access. My insider status made passage through both the managerial and clinical gatekeepers involved with the service users relatively easy. Having kept them informed during the planning stages of the research no blocks were put on the access. The consultant decided that some service users should be excluded for clinical reasons as she felt that their mental health symptoms could be exacerbated by involvement in the research. However, as has been noted, my professional status and long-standing relationship with some service users gave me the ability to negotiate inclusion of some that had originally been deemed inappropriate.

When researching service users it is not sufficient to obtain permission from those directly involved with the subject population either managerially or clinically. Holloway and Wheeler (1996) point out that research protocols dealing with sensitive issues should always be submitted to an Ethics Committee to seek approval.
Unfortunately Ramos (1989) found that health professionals do not have formal instruction in the ethics involved in qualitative research as they are more used to protocols in the field of biomedical research or quantitative large-scale surveys involving random sampling. Researchers submitting proposals to Ethics Committees involving qualitative research may need to explain and defend their design and methods in a way not demanded of more quantitative orientated protocols.

Having obtained a positive response to my research from the consultant psychiatrist, the consultant psychologist and the unit manager, I contacted the chairman of the Ad Hoc Ethics Committee of the NHS Trust responsible for my proposed sample frame. The existence of this Ethics Committee was not widely known to staff in the Trust and it had taken me six months to find out whom to contact for my previous research. I submitted my protocol, which was circulated to the members of the committee and after two months obtained their approval and encouragement.

However, the NHS Trust was in the process of merging with a neighbouring trust and the chairman suggested that I might like to submit my protocol to the Local Research Ethics Committee which covered both Trusts.

Ramos' (1989) findings proved true, as the protocol application forms were designed for quantitative studies and many of the questions were not relevant for my research. I filled in their eight page ("Shortened student") application form and enclosed my interview schedule, sample information sheets and consent forms for the two stages of the research. However, permission was refused because they wanted changes made to the information sheets and consent forms and the Ethics Committee demanded that the tapes recorded in Stage 2 of the research be destroyed at the end of the research: "N.B. If you are using Video or Audio recordings we must have your assurance that these will be destroyed at the end of the trial". I altered the information sheets and consent forms, but after discussion with my University supervisors I replied that destruction of the tapes would be detrimental to both the service users and me, because if at any time in the future a claim was made against me for causing harm when interviewing I would have no record of what took place. However, the Ethics Committee still had further issues regarding retaining the tapes and the wording of the information sheets and consent forms referring to the taping. After further protracted correspondence, and following seven months of negotiations, agreement was achieved and consent was given. Having gained the two NHS Ethics Committees’ approval I submitted my protocol to the University Advisory Committee on Ethics, which also appeared more
attuned to biomedical and quantitative research and it was refused because: the Information Sheets did “not state what the study is for and how participation by the volunteers will be of benefit”, and they wanted clarification about the ‘[Name] Project’ which was mentioned in the research. An explanation of the Project was given, but it was necessary to explain that giving too much written information regarding the research to people with enduring mental health problems could confuse and alarm them and change a pleasant exchange into an interrogation. There was no definable benefit to the sample as there might be in a drugs trial. Approval was obtained, but the whole process of obtaining Ethics Committees’ permission had taken a frustrating twelve months of negotiation.

4.3 Stage 1 Research Design
The research was in two parts. Stage 1 was quantitative when I interviewed service users using an interview schedule, to obtain an overview of their religious interests, needs and practices and ascertain how many considered that they had had a religious experience. From the initial interviews I was able to identify service users who were religious and had had religious experiences, who would be suitable to undertake recorded in-depth interviews in Stage 2 of the research.

An inductive analytic approach was found to be most suitable for the research, because I was not testing a hypothesis but exploring an area of interest and attempting to generate theory grounded in the data. Strauss and Corbin point out that the method was reliable because: “Both theory and data analysis involve interpretation, but at least it is interpretation based on systematically carried out inquiry” (1998:8). Although the Stage 1 would be quantitative and analysed statistically, it would be the analysis of the Stage 2 in-depth interviews that would provide the data that would be subjected to what Strauss and Corbin described as a “nonmathematical process of interpretation, carried out for the purpose of discovering concepts and relationships in raw data and then organizing these into a theoretical explanatory scheme” (1998:11). In other words, the Stage 2 in-depth interviews would not be analysed statistically but scrutinized for concepts and themes occurring in the data which would answer my research questions and enable me to theorise why service users look to religion. As Dey (1993:30) notes, qualitative data analysis reveals “elements and structures” in the data which assist in making connections between concepts, in order to produce social explanations (Mason 2002) for the emerging arguments. Lofland and Lofland (1995:181) conceive qualitative data analysis as an inductive and emergent process that has to be “worked at” (Atkinson
1990) by the researcher. Despite limitations this process can be aided by CAQDAS (Computer-assisted Analysis of Qualitative Data) using a code-and-retrieve approach (Coffey and Atkinson 1996; Silverman 2000) to identify patterns in large volumes of text, thus enabling the researcher to identify examples of key concepts. As Seale (1999:89) points out, using illustrative examples of key concepts within the data enables the researcher to identify concepts used by participants to navigate their social worlds, which can then be used to form theoretical concepts by the researcher.

This research approach was particularly appropriate because the research was breaking new ground. Although the research needed to be reliable and valid, grounded theory supported a creativity of thought whilst providing a research process though which to analyse the data.

Of the approximately 150 service users treated in the Psychiatric Service I planned to interview a sample of 100, as time would not allow me to attempt to interview all 150 and I believed that I would obtain saturation from two thirds of the sample. I would undertake a standardised interview using an interview schedule and fill in the service users' responses in front of them. This would consist mainly of closed questions, but with a few open ones to enable them to expand their answers. The responses would be entered into a SPSS spreadsheet for analysis. From the sample would be selected the candidates for the second stage of the research – recorded in-depth qualitative interviews.

The interview schedule would be piloted on a similar sample of psychiatric service users.

4.3.1 The Sample

Due to the changeable nature of the mental health of the relatively small research population, and the likelihood that some service users would be unwilling to take part, I did not want to restrict the selection of the sample in any way. It was not possible therefore to use probability sampling, which would give "high reliability and high generalisability of the results" (Sarantakos 1998:141), as I was aware that it was unrealistic to give every service users the possibility of being selected when some service users would be removed from the research by the staff as unfit due to their mental state. I therefore chose to use non-probability sampling with the understanding that I would not be able to claim that the findings would be representative of the whole population. However, by interviewing two-thirds of the population I felt that as far as
possible they would represent a large proportion of whole Service.

To obtain my sample I acquired the list of service users being treated by the Service at the commencement of the study, and went through the list with the consultant psychiatrist to obtain her agreement that I could interview each service user. This was essential because she had the power to cancel the research if any of her patients were harmed by it. Initially she removed nine service users, but two were reinstated when they were asked if they were willing to answer my interview schedule. Both knew me personally and were happy to help with my research. Of the other service users, two were suffering from dementia, three were known to be upset by religion and the other two she felt were too anxious or psychotic to be interviewed. With the remaining approximately 143 service users, (during the study some service users were discharged and others were admitted) I decided to use a combination of ‘cluster’ (Oppenheim 1992:40) and ‘accidental/convenience’ sampling (Sarantakos 1998:151), so that I would get a cross section of all the service users by interviewing a number of them at several locations. There were diverse means of contacting service users: at their place of sheltered work; at home; at the three doctors’ clinics; or when attending the ‘Depot Clinic’ or Pharmacy. The latter three all took place at one location at different times, so I kept checking the appointment registers to find out when service users whom I had not interviewed would be present. All service users kept doctors’ appointments, which enabled me to interview those who did not attend any of the six work places, were working during the day, or I did not want to interview at their home for reasons of personal safety.

My intention had been to interview all service users attending the clinics because that would give each service user the greatest opportunity to be interviewed. However, in practice this did not work because some service users only saw the doctor once every six months and I could not wait that long on the off chance of interviewing them. Also, as it took up to half an hour to interview each person and the clinic appointments were usually only a quarter of an hour, I missed service users while speaking to a respondent, or they could not keep their transport waiting to talk to me. Nevertheless, I was able to make many appointments to interview at a later date. I found that telephoning to make an appointment invariably brought a negative reply, whereas service users whom I approached in person were in the main willing to answer my interview schedule.

Of the potential 150 respondents seven were removed by the consultant (three men, four women), five refused to be interviewed (three men, two women), one man died, and one
woman was too psychotic while the interviews were taking place to be asked. Of the remaining 136 service users in the Service fourteen women and twenty-two men were not interviewed because time did not permit and I had reached the point that I believed would give saturation of the sample – 100 respondents. Only the gender was known about the respondents not interviewed because demographics of the sample were obtained during the interviews from the respondents.

4.3.2 Questionnaire Construction

Oppenheim warns that “questionnaires do not emerge fully fledged; they have to be created or adapted, fashioned and developed to maturity” and then “every aspect of a survey has to be tried out” to make sure that they “work with our population and will yield the data required” (1992:47).

The research question had to be conceptualised and the aims of the study operationalized before deciding what data to collect.

There were several issues that I wanted to investigate concerning the spiritual interests and needs of the service users, and how these interfaced with their status as ‘patients’². I wanted to examine the demographic breakdown of my sample in relation to their spirituality and where possible compare it with other populations. I was also interested to know if my sample showed the same level of spiritual interest as the Mental Health Foundation sample (McKerrow and Faulkner 1997).

There were several research questions that needed answering:

1. How similar or dissimilar was my sample of psychiatric service users to the normal population?
2. Was there a gender difference in the respondents’ views?
3. How did my sample compare with other groups of service users?
4. What part did religion play in the service users’ lives?
5. How many respondents reported having had a ‘religious experience’?
6. How did the dual labels of ‘mentally ill’ and ‘religious’ impinge on the service users’ lives?
7. How free were the service users to talk about their mental health problems and religious ideation?

However there was an overarching research question that the thesis would endeavour to

² Service users are referred to as ‘patients’ when speaking about people being treated by a psychiatrist either in hospital or in the community.
What causes people with enduring mental health problems to look to religion, and what do they find there?

To help obtain a picture of how other people understood my research questions I discussed the subject widely. In particular, I examined religious issues with medical colleagues and psychiatric issues with religious friends, to find out what understandings each had of the other.

Where possible I used questions from other surveys to make comparisons with other samples e.g. the World Values Survey 1999 (WVS) and European Values Survey (EVS) 1990; and Fitchett et al (1997).

4.3.3 The Stage 1 Interview Schedule

I decided to use an interview schedule (Appendix 3) in a standardized interview because I felt that I would get a better response rate, and it would ensure that the data gathered was as accurate as possible: I would know that the questions had been answered without prompts from other service users, and that those with poor literacy skills had correctly understood the questions. The benefit of a structured interview by one researcher was that 'stimulus equivalence', the notion that each respondent will understand the questions in a given way (Oppenheim 1992:86), could be ensured. Oppenheim pointed out that the interviewer could use judgment in departing from the text to explain or use a more familiar re-wording but without being directive, which again was facilitated by one researcher with full knowledge of the survey. Oppenheim (1992:87) divided questions into three types: 'factual questions' where the interviewer could offer explanations and correct misunderstandings; 'attitude and opinion questions' where no explanations or rewording would be allowed; and 'classification questions' where interviewers would be expected to provide probes to make sure they had correctly obtained all the information needed. Without the benefit of explaining some of the questions, or slightly re-wording them for clarification, I felt that many service users would have had difficulty correctly expressing their views and the data obtained would have been less complete.

I produced a series of 'show cards' (Oppenheim 1992:90) in a book which was placed on the table in front of the service users. The printing was in a large bold font which could be read easily at a distance, and the appropriate card was shown for questions marked with a (see Appendix 3). The cards enabled service users to see the answer
options as I spoke them, which facilitated a relaxed interview as anxious respondents did not have to ask to have the options repeated.

Before each interview I handed the service user an explanation of the research, which I read out to any who wanted me to (Appendix 1) – some service users had poor literacy skills. After answering any questions about the research each respondent was asked to sign a consent form (Appendix 2), which again I read if necessary. Initially I let the service users keep the information sheet, but found that in one place of work it was circulated amongst the workers while packing spoons and became the focus of the day’s rebellion, and service users were warned off seeing me by their fellow workers. After that occasion, I gave a sheet to respondents who wanted one and found that most did not want it, and I had no further problems of that kind.

Oppenheim believed that personal data collection could be ‘off-putting’ for respondents and should go at the end of the questionnaire (1992:109). However, I considered that with my sample group it would less threatening to start with basic demographic information that they were used to giving to staff, to build rapport and set the service users at ease. Unlike Oppenheim, I felt that to launch straight into my area of interest, religion, would not arouse their interest but rather raise their anxiety level. This proved to be the case. To overcome embarrassment when asking their age, I asked them to point to the age groups on the ‘show card’. Often there was a slight titter of awkwardness, but it broke the ice and most interviews became relaxed encounters.

To assess social status was problematic because of the effect of ‘social drift’ down the social scale with psychiatric service users. I asked what was their terminal age of education, their present or last occupation, and what was their present employment status.

Another concept was not easy to examine – socialisation. Questions were asked about their living arrangements, whether they knew their neighbours, if they belonged to any clubs and if so which ones, and how they spent their free time. I wanted to see if isolated service users were more likely to seek help from religious organisations. One of the standardised assessments filled in by medical staff with the service users looked at their integration with the general public. These assessments showed that most patients had not made a friend since becoming ill and had no friends outside the psychiatric services. I wondered if finding out about their use of free time and club membership might shed some light on those findings.
Having talked about non-intrusive matters, I then turned to religion and asked if they had had an experience that they might call ‘spiritual’ or ‘religious’. Most respondents had no problem with the concept, but for those that wanted clarification about what constituted a ‘religious experience’ I asked if they had experienced anything strange or out of the ordinary that they might give a religious meaning to. For service users who answered ‘yes’ they were asked to describe their experience.

The principle indicator for my requesting a second in-depth interview was having had a ‘religious experience’. However, it was important to know the nature of the experience and if it appeared to have any spiritual content, or was a one off drug-induced phenomenon. I also wanted to gather as much data as possible about each experience in case a respondent would not agree to a second in-depth interview. I was aware that some service users would not be interviewed a second time, and some would not be recorded. It was important therefore to take down a written description of their experience while they answered the interview schedule. One very interesting woman, whom several staff had warned me about, came with her carer to a consultant’s appointment and I completed the interview schedule while she spoke very animatedly to me. However, she would not consent to speak to me again as speaking about her florid experiences alarmed and distressed her.

The next two questions were taken from the World Values Survey 1999 (WVS) so that I could compare my sample with the population of Great Britain. One question asked the service users to describe their religious status as ‘religious’, ‘not religious’, ‘a convinced atheist’ or ‘don’t know’. I found the same problem that Hirst (1999) experienced with his middle class housing estate sample in Southampton. Many service users did not like referring to themselves as ‘religious’, particularly the ‘born again’ and evangelical Christians. I had to explain that the categories had to be the same as the WVS for comparison. However, unlike Hirst I did not want to change the categories thereby preventing comparison with the general population. The other WVS question asked if they attended a church service at Christmas or Easter.

Respondents were asked if they attended a service of a religious group and those that attended services were asked which religious group they frequented and how often. Of particular interest to me was how well the service users integrated into the normal population of the church: ‘how many people did they know in the congregation’; ‘had they talked to anyone in the congregation about their mental health problems’; ‘did they find the congregation helpful if they had problems’; ‘what did they find helpful and
what was unhelpful?’

The respondents who did not attend a religious service were asked if they had attended religious services at any time in their lives. Those who had attended services were asked when they last attended: ‘within the past year’; ‘within the past five years’; ‘over five years’. I was interested to know why they had stopped attending, particularly if their mental illness was the cause. The question was open without direction from me.

The next questions were from the WVS and I was interested that they had been asked of the general population: ‘did they get comfort and strength from religion?’; ‘had they been brought up religiously at home?’; ‘and on a scale of one to ten how important was God in their lives?’ I was surprised by how easily all the service users were able to point out where on the scale God fitted into their lives.

The European Values Survey 1990 (EVS) had looked at how often people thought about the ‘meaning and purpose in life’. This was included in my interview schedule as well as a question asking if they ever ‘thought about death’. The response options were: ‘often’; ‘sometimes’; ‘rarely’; ‘never’; ‘don’t know’. I wondered how similar people with mental health problems were to the general population or if they contemplated the existential problems more, or had a negative view of life while considering ‘death’.

Questions were taken from the EVS 1990 about beliefs. The first question asked which statement came closest to their beliefs, there is: ‘a personal God’, ‘a spirit or life force’, ‘don’t know’, ‘there is no spirit or life force’. Some respondents were uncomfortable with the concept of ‘a personal God’ and would have preferred something less intimate, whereas the Christians agreed readily with the statement. Again I had to explain that the statements were taken from a large survey and I could not alter them. They were asked further questions about their viewpoints: whether they believed in ‘God’, ‘life after death’, ‘a soul’, ‘the devil’, ‘Hell’, ‘Heaven’, ‘sin’, ‘resurrection from the dead’, and ‘re-incarnation’. All responses could be compared to the general population.

I wanted to look at the part that superstitions played in the service users lives. I asked them if they owned religious objects or lucky charms and if they felt that these could help or protect them. I asked how often they read their horoscopes, and if they believed that horoscopes could affect their lives.

Using the EVS questions I enquired if they ‘prayed’ or ‘meditated’, and how often they prayed to God outside religious services.

Fitchett et al (1997) looked at the religious needs and resources of a sample of fifty-one
psychiatric in-patients in the US. To compare my sample with another group of psychiatric patients I used his Likert scaled questions to investigate issues of importance to my service users. They were asked to rate on a five-point scale from ‘very unimportant’ to ‘very important’: ‘to know God’s presence with me’; ‘to have a purpose and meaning in life’; ‘to be relieved from the fear of death’; ‘to be able to pray’; ‘to have the sacraments and communion’; ‘to have the care and support from another person’; ‘to have a clergyman or woman visit and pray with me’. Most respondents rated ‘support from another person’ to be very important to them but few affirmed the need of a visit by the clergy.

Finally, I wanted to look at the spiritual interface between the service users and the clergy and psychiatrically trained staff. The respondents were asked if they had spoken to any clergy about their mental health problems. Those respondents that had spoken to clergy were asked where this took place: ‘in hospital’; ‘in the community’; ‘in their church’ or ‘other’. I wanted to know if they found it helpful and if anything would have made it more helpful.

All service users were then asked if they would be happy to talk to a doctor or some other medical person about any religious ideas or religious experience they might have had, and if in fact they had done so. Those who had spoken to a medical person were asked who this was and over what time period: ‘within the last six months’; ‘6-12 months ago’; ‘1-2 years’; 2-5 years’; ‘more than 5 years’. I wanted to know how they felt their beliefs had been received: if they were ‘understood’, ‘respected’ and ‘shared’. The last question that enquired if the patient felt that the member of staff ‘shared their beliefs’ attempted to investigate any differences of culture that might have been present between the service user and staff. I was dissatisfied with this question as I did not feel that I obtained the data I was seeking. Most service users had no problem answering in the negative or affirmative, but without asking them further information about their beliefs, and in what way they were shared or not shared by staff, their answers were inadequate. This pointed to one disadvantage of using an interview schedule, where the interviewer must confine the questions to those on the sheet. The enquiry about staff sharing their beliefs involved a closed attitudinal question requiring a ‘yes’ or ‘no’ answer and no guidance could be given. This would be one area investigated in the in-depth interviews in the second stage of the research.

Analysis of the findings of the Stage 1 interview are examined in Chapter 5.
4.3.4 Pre-Pilot Study
As the population I was investigating was vulnerable I decided to use the interview schedule first on people who would not be upset by the encounter, and who would be able to give a clear articulation of their experience of answering my questions. The interview schedule was used with six people, and ambiguities in the wording were rectified. Five people had no mental health problems and one was an ex-patient.

4.3.5 Pilot Study
The interview schedule was piloted on twelve service users, in the Community Day Hospital in an adjoining town within the same Trust that treated a similar group of people, i.e. those suffering from enduring mental health problems. Some service users from this day hospital were referred into the Psychiatric Service so I felt that they were an ideal population.

At this stage I was still waiting for permission to undertake my research from the Medical and University Ethics Committees. However, the manager of the day hospital, with whom I was working at the time, explained my research to her staff and they asked the service users if anyone would be willing to answer my questions. I felt that as no coercion was placed on the service users they constituted a voluntary sample, and as the consultant and staff were happy about my research I could proceed with the pilot study because I had obtained permission from the NHS Ad Hoc Ethics Committee who were responsible for the patients.

Each service user read the Information Sheet explaining who I was and the nature of the research, and if they wanted to keep a copy they were given one. The service user then read and signed a consent form. I administered the interview schedule by reading out the questions and writing down the answers in front of the respondent. All open questions were read back to check for accuracy.

The survey took about twenty minutes including signing the consent form. Those who had religious experiences took a little longer, as did some who expressed some deep feelings. None took longer than thirty minutes. After the first pilot interview I produced show cards to make the questioning more relaxed and explicit. This proved to be very helpful as the service users had two cues: auditory and visual. The show cards were printed in a very large font and placed in a flip chart book, so that they could easily be read at a distance and I would not intrude into the service users’ space. This was important as I was dealing with unknown, vulnerable people, asking potentially
sensitive questions that could trigger a painful response. The cards were most helpful when asking multiple-choice questions as the respondents could look at the categories as I read them out.

Some changes were made following the pilot-study. I had used a WVS 1990 question: “Do you personally think it is important to hold a religious service for birth, marriage and death?” I felt the question was not relevant to the respondents and was not germane to my research, so it was removed. However, a question was added at the suggestion of one of the service users “Have you ever felt in the presence of God?” This was piloted on subsequent respondents and found to be applicable to service users’ experience of the supernatural.

Questions on service users’ living arrangements were altered. Inquiring about their tenure seemed superfluous, and asking how many people and of which sex they lived with was not helpful. Both were removed, and in their place I asked if they lived alone or with others with the options given of: ‘alone’, ‘family’, ‘group home’, ‘with friend’, ‘in-patients’; or ‘landlady’. This gave me an understanding of the level of care they required from the professionals.

The pilot study was beneficial in that it gave insights into what was relevant to the research and the value of each question used. After making changes I felt that the interview schedule would produce data to answer my research questions, and that I had become more confident in interviewing service users.

4.3.6 Preparation

As soon as the Local Medical Ethics Committee and Surrey University Advisory Committee on Ethics had approved my research I was prepared to start interviewing immediately, having used the previous year undertaking a pilot study and honing my interview schedule.

I had been in regular contact with all the key figures in the Psychiatric Service, but I needed to inform the rest of the staff involved with the service users about the nature of the research and how it might impact on them. All service users had a key worker who was responsible for their needs. It was essential to gain their approval and co-operation, particularly as some of them held negative views about religion. I had worked closely with nearly all of them, although having to wait so long for the Ethics Committees to give permission meant that new staff had joined the team since I had left.

I talked with staff individually about the research, and then gave a presentation at the
weekly staff meeting. Simple issues were raised and queries sorted. Everyone appeared interested by the research and willing to give me their assistance, particularly in encouraging their service users not to be frightened of the procedure. Only one staff member tried to stop the research. He felt that because I was no longer working for the Trust, being given a list of the patients currently treated by the Psychiatric Service breached confidentiality. As he was always difficult and contentious with all the staff he was firmly declared to be out of order by the consultant psychologist, who said that as the Local Medical Ethics Committee was happy with the research he could not stop it. It was at that moment that all the time spent waiting to obtain their permission was worthwhile. I was aware how easily one hurdle could undo months of minute preparation and terminate the research.

With the consultant’s approval her secretary gave me a list of all the patients being treated at that time by the Psychiatric Service, with the names of their key workers. The consultant psychiatrist and the consultant psychologist marked people that they felt they would prefer me not to contact.

I spoke to each key worker about their service users, to make sure they were happy for me to talk to them, and where I might find them. They gave me helpful information such as: “deaf as a post”; “you will be there for hours”; “the dog will have to come too”; “be in a public place”; “may be more co-operative if you leave it a while”.

4.3.7 Reaction to the Stage 1 Interviews

My reactions to the Stage 1 interviews depended on the service users and the difficulty or ease with which they participated. Some respondents were very forthcoming and made comments such as: “pleased to have someone ask me my views”; “glad to have some time off work”; “I’m happy to see you back”; “delighted to help you with your research”. Others were more difficult to interview: suspicious; agitated being asked intrusive questions; mocked by their friends for talking to me; distracted by voices; or pre-occupied with their problems. Although the latter were much more tiring I was glad to have a full range of views as it reassured me that I was getting a good cross section of opinions.

One incident nearly terminated the research. In the weekly staff meeting it was reported that three patients were very upset by my interviewing about religious matters. I immediately spoke to the consultant psychiatrist and found out that of the three service users in question I had only interviewed one, and she had been very happy when I left
her. She was only known to me by face before the interview, and although she was pleasant throughout the interview she was considered by staff to be a very troublesome and sometimes aggressive person. Apparently, the interviewing had triggered memories of an action she had performed in a church thirty years earlier. When I spoke to her again, she was very happy to find that I did not think she was "evil". She was then quite content with the research and greeted me warmly every time I met her thereafter. Of the other two: one woman had been hassled by a cult in her group-home because the nurse in charge had been away; the staff never identified the third person, so the consultant assumed that it could not have been traumatic. It reinforced a need for the continual process of working with the gatekeepers to negotiate access. My role of insider was a great asset, as the gatekeepers knew the way I worked with service users and trusted my judgement.

The data were entered into an SPSS file for analysis.

4.4 Stage 2 Interviews

The last question on the interview schedule asked whether the respondent would be willing to take part in Stage 2 of the research, which would be an unstructured recorded interview to examine the religious experiences in people with long-term mental illness.

4.4.1 Stage 2 Sample

Forty-eight service users, (twenty-two women, twenty-six men) had agreed during the Stage 1 interview to take part in the second stage of the research, although I was aware that some might change their minds later, become ill or be discharged from the Service, and this proved to be the case: four (two men, two women) changed their minds; two women became ill; and six (four men, two women) were discharged.

The criteria for asking respondents to participate in an in-depth interview were somewhat fluid. As well as having had a religious experience there had to be evidence that the spiritual realm was of importance to the service users. Eight service users (seven men, one woman) were not asked because their experience appeared to be a one-off occurrence, often drug induced, and they were otherwise not interested in religion. I felt that these respondents had told me all there was to know of their religious story. Six (three men, three women) respondents were not asked for a second interview because the process of the initial interview had been very traumatic for them. In the case of two women and one man this was a wise decision, because their key workers reported to me that they had been disturbed by being interviewed. Four men and one woman declined a
second interview. It was interesting to note that none of them knew me, and two were newly referred into the service: both reasons to make them unwilling to reveal their inner religious lives.

4.4.2 Stage 2 Interviews
Appointments were made with the service users to interview them either at a NHS facility or within their own homes. Negotiating a quiet room within a NHS unit was sometimes difficult but was made easier by my insider status. The interviews were recorded on a mini-disc player, which gave seventy-four minutes of uninterrupted recording time so that new tapes did not have to be installed in most cases, and once switched on the recorder could be ignored. A few interviews used two tapes. Before each interview the service user was given the Information Sheet explaining about the recording and that they had a right to stop the interview at any time without it being detrimental to their treatment within the Service. Three respondents (one man and two women) asked if they could have a copy of the tape, but I explained that it was on a mini disc and I had no way of copying it but they could have a written transcript of the interview. The two women wanted a transcript, and were given one, but the man did not.

The Stage 2 interviews sometimes took place up to a year after the initial interview for a variety of reasons: the one hundred Stage 1 interviews took a long time to complete because it was difficult making contact with the service users at a time that was convenient to them – any suggestion of urgency would have been very counterproductive; service users’ mental health fluctuated and they were unable to be interviewed; their personal crises had to be resolved; and they failed to keep appointments and they had to be rescheduled. Although this was not ideal it did not appear to cause any problems to the service users. If necessary I mentioned details they had given me on their interview schedule and read to them their related religious experience.

With such a vulnerable and fragile sample I was concerned that the interviews should be as informal and relaxed as possible, so I decided not to have a written interview guide while recording. However, there were certain themes that I wanted to investigate, although I knew that I would not necessarily be able to cover all of them with each interviewee.

There were issues that related to their religious lives: religious upbringing; schooling;
religious practice; friendships. Religious beliefs needed investigating, in particular in relation to their mental illness. I wanted to explore their religious experience and see if it had an ongoing affect in their lives. I was particularly interested in their private religious lives and if they spoke about it to anyone.

Then there were questions about how the medical professionals dealt with service users’ spiritual needs: did they report that the medical staff considered their religious nature in relation to the care they gave them?; did they refrain from admitting to spiritual interests because the medical professionals might pathologise an area of sacred importance to them?; did service users seek help from clergy and keep it compartmentalised from the medics, and if so why?; was the power of the medical profession so weighted against the service users that they feared being committed under a Section of the Mental Health Act as insane for expressing religious ideation?; did service users consider their spiritual lives to be no part of the healing offered by the medical team?

I also wanted to find out: why are some service users religious and not others?; are there varying degrees of religiosity?; is religion regarded as a need, and if so why do some people have this need and not others?; what benefit do people derive from attending church?; what is the profile of those with spiritual needs and do they go to church?; do the service users need a dedicated religious service and if so why?

All the service users knew that I was interested in their religious lives and I usually started by asking more about their religious experience, but very quickly the conversation would often develop a life of its own. Most interviewees had issues they wanted to deal with, or concerns that worried them in the religious realm and we sometimes explored them at length. When an issue arose that had not been included in my topics of interest I expanded my mental interview guide to include it, and if appropriate brought it into subsequent interviews. However, with such a vulnerable group I did not want to put ideas in their minds or lead them. ‘Stigma’ was brought up in early interviews but I was very cautious about asking all the service users if they felt ‘stigmatised’. It is such a widely used term with a very broad definition, and I did not want the conversation deflected from religion unless stigmatisation was relevant to the topic and a dominant feature in their lives. However, having been alerted to a sensitive issue it could be lightly touched upon in subsequent interviews to see if it had deep resonance with the interviewee in which case it could be explored further. Other issues that came up were childhood abuse, homosexuality, adoption, and abortion, which had an effect on both the individual’s spiritual and mental lives. For example, adoption lay
at the heart of deep pain in the lives of four interviewees, both their own adoption and that of their children. Clearly I would not want to ask all the service users if they had experience of adoption.

This form of interviewing had strengths and weaknesses. One strength was that the service users were free to talk about their concerns and were not constrained by my pre-conceived notions about religious issues in their lives. A drawback was that it made analysing its contents to find themes running through the interviews difficult because there was little consistency in the interviews. However, I felt this proved the benefit of using an inductive analytic approach to let the theory come from the data which was obtained from respondents being given a free rein of self-expression.

To facilitate the analysis I transcribed all the interviews in full, entered them into the WinMax computer programme, and subjected them to microanalysis (Strauss and Corbin 1998) to generate initial codes with properties and dimensions. These codes were then grouped thematically. However, before I finished the interviewing an upgraded version of the computer package MAXqda became available with a rich text format that was much more convenient to use. It necessitated recoding the interviews that had already been coded, but this was beneficial because my theoretical insight had been enhanced over the period of time and I was able to code more thoroughly.

The main themes that emerged from the analysis of the cases were: 'experience'; 'mental illness'; 'religion'; 'professionals'; 'places'; 'families'; 'stigma'. At this stage integration was necessary to reveal the core categories that represented the main essence of the research. As Strauss and Corbin note, although a sudden insight might take place,

...integration is an ongoing process that occurs over time... It is an interaction between the analyst and the data. Brought into that interaction is the analytic gestalt,...the evolution of thinking that occurs over time through immersion in the data and the cumulative body of findings. (Strauss and Corbin 1998:146)

It is necessary to recognise the relationship between the concepts, but this entails selectivity and interpretation. I found myself going back again and again to all the transcripts and field notes asking myself: 'what are these narratives telling me?'; 'what is important in these data to my respondents?'; 'what answers my research question?'

There came a moment of insight when I could answer those questions and find a central category that was indicated within most of the cases: 'seeking ontological security'.

The analysis of the Stage 2 interviews will be examined in Chapters 7 and 8.
Chapter 5
Religiosity of Mentally Ill People: An Overview

5.1 Introduction
As has been shown very little research has been undertaken to investigate the religious lives of people suffering with enduring mental health problems. This research was undertaken in two parts: the first quantitative and the second qualitative. This chapter will analyse the data from the initial interview, which was recorded on an interview schedule when one hundred service users from one Psychiatric Service were questioned about their religious views, activities and beliefs.

At the commencement of the research 156 service users were being treated within the Psychiatric Service, of whom 95 (61%) were men, and I interviewed 63 men and 37 women. They were all of working age 18-65 years, and all lived in the local community in accommodation with different levels of care, from none to full time professional attention.

5.2 Characteristics of the Sample – Demographics

5.2.1 Gender and Age
It has been noted that gender and age have a bearing on religious practices and beliefs. Davie found women are “almost always more religious than men” (1994:117) and “older people have always been more religious than the young” (1994:121)

The British Social Attitude Survey 2001 stated that:

Religion clearly plays a more important role in the lives of older people than in those of younger people. In 1999 one in six people aged 65 and over who said that they belonged to a religion or were brought up in a religion attended one or more services a week, compared to one in twenty of those aged 18 to 24. 27% of 18 to 24 year olds said that they had no religion whereas only 2% of those 65 and over said that this was the case.

However, patterns of believing do not always correlate with patterns of practice. Religiosity changes with age and is higher for men and women at both ends of the age spectrum. As women’s life expectancy is longer than that of men there will be more religious women than men alive at any one time. However, even controlling for age
there is a gender difference in religiosity.

Bruce (1996:220) linked the greater religiosity of women to secularisation, when he argued that as religion became a more personal matter practised in the private sphere of the home it entered the area where women predominated and its relevance diminished for men. God is viewed in distinct ways according to gender according to Davie (1994:119): women see God as a god of love, comfort and forgiveness, while men were more likely to see God as a god of power and control. She also asserted that women were more likely to believe in the importance of private prayer and to practise it. Davie suggested that women were more religious than men because of their closer association with the central issues of life that were core interests of religions: birth, death, caring for the elderly and dying, and nurturing the young. As she wrote:

Very few women give birth without any reflection about the mysteries of creation and very few people watch someone die (especially a close relation) without any thought at all about why the person lived or what might happen to them after death. (Davie 1994:120)

Another important issue that Davie pointed to was the generation gap between pre-war and post-war populations in their knowledge, experience, language and vocabulary. Pre-war generations, whether they practised their faith or not, possessed "a degree of religious knowledge that had some sort of connection with orthodox Christianity" (1994:122). People held a 'shared vocabulary' and a 'common language', which was not present in the post-war generations. Assumptions could be made about the pre-war generations having had some experience of churches, even if in their youth, but this would not necessarily be true of post-war generations. Where once religious education in schools would have been solely Christian, now many faiths are studied as a philosophy rather than as a creed. Although there remained a nominal belief in God it was less influenced by orthodox Christian teaching, and so intercourse lacked a common knowledge and vocabulary. In fact a recent study showed that significant groups of young people held no religious beliefs at all (Collins 1997).

When I enquired whether my respondents had been brought up religiously at home half the men (31 men, n=63) and 59% of the women (22 women, n=37) affirmed that they had, therefore slightly more women than men had religious instruction at home. Just over half (53%) of the total sample of respondents said that they had been brought up in a religious home. 21% of those brought up religiously and 6% of those who had not, said that they now attend a religious service. It appears that beliefs are relayed through the family; in my sample respondents from a religious family were nearly four times as
likely as those who did not to attend a religious group now.

If, as has been shown, women and older people are more religious than men and younger age groups, it was important to understand my respondents in terms of their gender and age. Department of Health Statistics show that more women than men are admitted to psychiatric facilities each year (Pilgrim and Rogers 1999). However, my sample did not reflect this gender breakdown, because within the Psychiatric Service that my respondents attended there was a higher proportion of men to women. This may have been due to an historic emphasis on a work-orientated treatment regime, particularly factory work, rather than cognitive talking therapies that may be more conducive to women. The proportion of men to women in my sample was comparable to that within the Psychiatric Service.

The sample was also within the older age bracket with nearly half of the respondents in the age group of 45-64 years, and nearly three quarters being over the age of 35 years. This again may not have reflected the age of service users nationally, but it did represent the Psychiatric Service, where work-orientated treatment was stressed and their mental illness was chronic rather than acute.

Table 5.1: Number of respondents by age groups and gender \( (n = 100) \)

<table>
<thead>
<tr>
<th>Age of service users</th>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>18-25 years</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>26-34 years</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>35-44 years</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>45-64 years</td>
<td>27</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
<td>37</td>
</tr>
</tbody>
</table>

5.2.2 Social Class and Occupation

Bruce (1996) pointed out that there were associations between levels of education, income or social class and self descriptions of religiosity, but that they tended to run in opposite directions. Wealthier and more middle-class people were less likely to believe in God than poorer people, but they were more likely to practise a religious faith. Unskilled manual workers Social Class V were more likely to describe themselves as religious than the professionals and senior management in Social Class 1.

However, when looking at a sample of people with enduring mental health problems the attributes that can be used to identify social class are complex. The class system
depends on economic differences between groups of people and is characterised by control of material possessions. Ownership of wealth, and differences in occupation with inequalities in working conditions and pay exemplify the three main classes seen in British society: upper, middle and working classes. There is a degree of social mobility between the classes, and this is evident with service users when their mental illness prevents them from working in their chosen occupation, and they suffer ‘social drift’ (Pilgrim and Rogers 1999) as they cannot maintain their former standard of living. Loss of employment affects their material aspirations, their ability to maintain a good standard of living and even their accommodation. The term ‘social drift’ has been applied to service users whose mental illness causes them to go down the social scale.

As noted earlier in Chapter 2, sociologists had theorised on the correlation between social class and mental illness and noted the higher incidence of service users from poorer areas rather than in middle class neighbourhoods. However, they were divided on whether the mentally ill drifted to lower class areas or if the stresses of living in poverty, both materially and in terms of negative life experiences, caused higher levels of mental illness in the working classes. Pilgrim and Rogers (1999) noted that although social stress could be demonstrated to be correlated with social class it could not be proved to cause schizophrenia, although there was epidemiological evidence that social stress affected rates of recovery and relapse in patients with schizophrenia. Schizophrenia was responsible for several respondents being unable to work in their former well-paid occupations, with all the concomitant loss of material goods and lifestyle choices that are acquired through possession of wealth.

However, it was difficult to gain an accurate understanding of social drift in my sample. One Interview Schedule question asked, ‘What is your present/last occupation’? Although I was able to ascertain that the occupation given was the present one for eight respondents (seven were in full-time employment and one in part-time employment) the occupation given by the other eighty-eight respondents (four had never worked) did not stipulate when they had been engaged in this work. Also, it did not give a clear picture of whether this was their chosen occupation, or one that was taken as a result of downward mobility to a lower skill level as a result of their mental illness. In retrospect, because of downward mobility after mental illness, occupation may be a misleading indicator of the class of origin with a sample of service users. It might have been interesting to have noted both present and all past occupations to see if there was a pattern in the difference, but as has been noted in practice most service users were
unemployed at the time of the research so did not have a present occupation, and many of the younger ones had never worked or just worked briefly in unskilled manual work. Respondents also interpreted the question in different ways: one woman who was at the time in sheltered work stated that her last occupation was 'cleaning', and only later mentioned that she was a trained teacher who had been forced to give up teaching many years before because of her mental illness. The fact that she had returned home to live with her professional parents in a middle class area but was financially very poor, being dependent on benefits, typified the problem of assessing service users' class. If class is identified through ownership of wealth and occupation (Giddens 1993) she was now working class, but she stated that she suffered within the Psychiatric Service because many service users, who would describe themselves as working class, ridiculed her for being too 'middle class'. They denigrated her because of the content of her conversation, her received pronunciation and her taste in music. In hindsight it might have been helpful to have enquired what their parents' occupations were, but that might have been deemed too intrusive and irrelevant to their lives.

The notion of 'believing without belonging' to a religious organisation was examined by Davie and she felt that this was seen at "its sharpest in urban working-class areas" (1994:106). She believed that this was due to their distrust of all institutions, including the church. In some sections of the working classes there had been no contact with the church through several generations, with a resultant alienation from institutional Christianity. The working classes did not perceive a need to express their beliefs in 'liturgical practice' and saw churchgoing as needless if not hypocritical. Hypocrisy was an issue raised by several of my respondents in relationship to churches. They felt that Christianity proclaimed that it was a religion founded on the concept of love; for God and for all people, but when they did not receive love and acceptance from Christians, and in particular within churches, they denounced them all as hypocritical.

Although my data may not have reflected the class of origin because of social drift, as noted above, and many service users were not currently employed, their given present/past/last known occupations were reduced into seven headings to correspond as far as possible to the classification of the WVS.

1. **Professionals**: three accountants, three teachers, a librarian, a scientist, an engineer, and a social worker.


3. **Skilled-Manual**: two electricians, a car mechanic, a cycle repairman, a hospital
technician, a carpenter, a mortician, a nursery nurse, a nursing assistant, a dental nurse, and a farmer.

4. **Semi-Skilled Manual:** twelve shop workers, two postmen, a laundry worker, a caterer, a timber salesman, a petrol attendant and a barman.

5. **Unskilled Manual:** eight factory workers, eight cleaners, three gardeners, four labourers, three drivers, a dustman, a shelf stacker, a paperboy, a dinner lady, and a messenger.

6. **Never Worked:** four respondents.

7. **Students:** five respondents.

The eight respondents who were in full-time employment were from all the classifications: **Professional** – an accountant; **Non-Manual** – a graphic designer, two office workers; **Skilled-Manual** – a nursing assistant; **Semi-Skilled Manual** – a shop worker; **Unskilled Manual** – a cleaner. The part-time worker worked in an office.

It was sad to note that because of their enduring mental illness none of the respondents was working in their chosen past profession, and it was unlikely that they would ever be able to work in their professions again – the working accountant had been a concert pianist but was no longer able to perform, and his accountancy jobs tended to be short lived because of his mental illness. Although the psychiatric service attempted to place service users in work experience and then employment in their chosen occupation, this was very often not possible. In some instances it was the stress of the work that had caused the breakdown and the service user did not want to return to the same situation. In others, the illness had produced an inability to work because of thought disorder and confusion, or high levels of drugs made concentration difficult.

The respondents were next asked how they were employed or how they currently spent their time during the day. Over half of them were in ‘Sheltered Work’, which consisted of employment in work units run by the Trust, to provide daytime occupation and training for the service users. The next largest category contained those who did not work (21%), although many of them attended drop-in centres run by the Trust. I did not record any activities other than work because the pattern was too irregular.

Seven of the service users were in paid full-time employment and one was in paid part-time employment. Only two were attending courses and one work experience on a full time basis. Eleven of the service users had a mixed programme, mostly working part-time in sheltered work and either on part-time work experience or attending a part-time course.

I was surprised that only three were attending courses or work experience full time. In
past years there had been a very close liaison with the local college of further education and many service users had taken the opportunity while in the service of enrolling for the heavily subsidised courses. Two staff had been employed to find work experience for service users and to assist them during their placements.

When compared to the WVS population in Great Britain the most obvious finding was the low level of employment in the psychiatric service users. The same proportions 2% of both samples were currently students. ‘Other’ in the WVS covered ‘retired’, ‘housewife’, self-employed’ but these categories were inappropriate for the psychiatric sample who were in the working age bracket so not ‘retired’, were occupied during the day as part of their treatment so were non classified as ‘housewives’, and were not capable of being ‘self-employed’. ‘Work experience’ had no equivalent within the WVS categories. ‘Work Experience’ for the service users was often the first stage to getting ‘full-time employment’ and therefore an indication of good functioning. ‘Sheltered work’ was work within the service and included occupations such as: factory work, clerical, horticultural, printing, arts and crafts, soft furnishings, picture framing and carpentry. The ‘mixed programme’ was a combination of any of four categories of ‘part-time employment’, ‘student’, ‘work experience’ and ‘sheltered work’. With the service it was important not to make value judgements about which could be classified as the most important work so users were entered as involved in a ‘mixed programme’.

Table 5.2: Current employment, service users compared to general population/percentages

<table>
<thead>
<tr>
<th>Employment</th>
<th>Psychiatric n=100</th>
<th>WVS n=1484</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time employment</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>Part time employment</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Unemployed</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Work experience</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Sheltered work</td>
<td>57</td>
<td>0</td>
</tr>
<tr>
<td>Mixed programme</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>42</td>
</tr>
</tbody>
</table>

Source WVS 1995

What became clear was the difference in patterns of work in the different age groups: only one third of the 18-25 year olds had ever had a job. Several reasons could be hypothesised for this finding: they had fewer years to find work; the early onset of some forms of schizophrenia meant they had suffered with mental health problems since teenage; changes in the expectation of the need to work due to adequate benefits;
increased use of illicit drug taking in the young. However, no diagnoses or work attitudes were recorded so no inferences could be made. A high proportion of the other age groups had been employed at some time in their lives. What was striking was that 90% of the professionals were in the age range of 45-65 years.

Table 5.3: Present/last occupation by age (n = 100)

<table>
<thead>
<tr>
<th>Present/last occupation</th>
<th>Age of Service Users</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-25 years</td>
<td>26-34 years</td>
</tr>
<tr>
<td>Professional</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Skilled Non-Manual</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Skilled Manual</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Semi-Skilled Manual</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Unskilled Manual</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Never Worked</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>17</td>
</tr>
</tbody>
</table>

If as Bruce suggests class correlates with certain religious patterns, i.e. professionals in Social Class 1 are less likely to believe in God but attend church, and the working class do not attend religious establishments but are more likely to describe themselves as ‘religious’ (Bruce 1996), this pattern should be evident in my sample. However, the picture was more complex: slightly fewer ‘professionals’ than ‘unskilled manuals’ described themselves as religious, but slightly more ‘professionals’ believed in God.

Table 5.4: Present/last occupation by religious status (n = 100)

<table>
<thead>
<tr>
<th>Present/last occupation</th>
<th>Religious status</th>
<th>Believe in God</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a religious person</td>
<td>not a religious person</td>
<td>a convinced atheist</td>
</tr>
<tr>
<td>Professional</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Skilled Non-Manual</td>
<td>14</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Skilled Manual</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Semi-Skilled Manual</td>
<td>13</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Unskilled Manual</td>
<td>18</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Never Worked</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>26</td>
<td>4</td>
</tr>
</tbody>
</table>

Comparing ‘professionals’ to ‘unskilled manual’ there was a slight difference in their religious status: 50% ‘professionals’ as opposed to 58% ‘unskilled manual’ described
themselves as 'religious'; however it was reversed when looking at their belief in God - 70% ‘professionals’ to 65% ‘unskilled manual’ believed in God. However, taking the top two categories as ‘middle class’ and the bottom two working categories as ‘working class’ there was no difference in their religious status, ‘professionals’ + ‘skilled non-manuals’ 63%, ‘semi-skilled manuals’ + ‘unskilled manuals’ 62%, but more people in the top two categories believed in God: 83% middle class - 70% working class. Therefore my sample did not follow Bruce’s (1995) findings. This could be due to the small numbers. However, the present/last occupations may have been when the service users were already suffering from a mental illness thus altering their religious beliefs; therefore inferences could not be made because, as has been noted, the timescale of the occupations and any link with the onset of their mental illness was not recorded.

To see if religious practice followed Bruce’s findings that the middle classes are more likely to attend church than the working classes I looked at patterns of attendance now and in the past.

Table 5.5: Present/last occupation by past and present church attendance (n = 100)

<table>
<thead>
<tr>
<th>Present/last occupation</th>
<th>Attend religious group NOW</th>
<th>Attended religious group in PAST</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Skilled Non-Manual</td>
<td>7</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Skilled Manual</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Semi-Skilled Manual</td>
<td>4</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Unskilled Manual</td>
<td>10</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Never Worked</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>45</td>
<td>26</td>
</tr>
</tbody>
</table>

50% of the ‘professionals’ still attend church, although 90% had attended at some time in their lives. With the ‘unskilled manual’ workers 32% attend now, and 68% had at some time attended church. Again taking the top two categories as ‘middle class’ 90% had at some time attended church, while of the ‘working class’ (‘semi-skilled’ + ‘unskilled manual’) 69% had at some time attended church. The numbers were small but Bruce findings were found to be supported by my sample: the working class respondents were less likely to attend church than the middle class ones were.

I was interested in Bruce’s statement concerning the differences between middle and working classes’ religious behaviour and beliefs.

92
The middle classes are much more decisive in their religious behaviour and narrow in their use of terms to describe it. More middle-class people are involved with the churches, but those who are not are less likely than their working-class counterparts to claim religious beliefs or describe themselves as religious. (Bruce 1995:52-53)

Looking at my ten respondents who were professionals a confused picture emerged: two went to church, were religious and believed in God; one went to church and believed in God but was not ‘religious’; two went to church but did not believe in God - one was ‘not religious’ and the other was an ‘atheist’; three who did not attend church were ‘religious’ and believed in God; one did not attend church, believed in God but ‘did not know’ if he was religious; and one was not religious, did not attend church and did not believe in God.

Table 5.6: Professionals’ church attendance and beliefs (n = 10)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Religious</th>
<th>Attends church</th>
<th>Believes in God</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>2.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>3.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>4.</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>5.</td>
<td>atheist</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>6.</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>7.</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>8.</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>9.</td>
<td>D/K</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>10.</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
</tbody>
</table>

Having seen that my professionals did follow Bruce’s findings that more “were involved with the churches...than their working class counterparts”, it was necessary to look at those who did not attend church to review their beliefs. Of the five non-attenders 80% (4) believed in God and 60% (3) were religious.

To test Bruce’s notion I looked at the unskilled manual workers to see if they were more likely “to claim religious beliefs or describe themselves as religious”.

Table 5.7: ‘Unskilled-manuals’ church attendance and beliefs (n = 31)

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Religious</th>
<th>Attends church</th>
<th>Believes in God</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>7</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>5</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>2</td>
<td>atheist</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>3</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>D/K</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>1</td>
<td>D/K</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>1</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
</tbody>
</table>
Of the five non-attenders within the 'unskilled manual' respondents 52% (11) believed in God and 38% (8) were religious.

Table 5.8: Non-church attenders: comparison of ‘middle’ and ‘working’ class religious beliefs

<table>
<thead>
<tr>
<th>Class</th>
<th>% Believers</th>
<th>% Religious</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle</td>
<td>80</td>
<td>60</td>
<td>5</td>
</tr>
<tr>
<td>Working</td>
<td>52</td>
<td>38</td>
<td>21</td>
</tr>
</tbody>
</table>

My sample did not follow Bruce's findings that middle class non-church attenders are less likely to define themselves as religious and hold religious beliefs than their working class counterparts: a higher percentage of professionals described themselves as religious and believed in God than did the unskilled manual workers. However, again the numbers were very small.

When making a comparison between the two classes the following was found: of the professionals 50% attended church, 50% were religious, 70% believed in God; of the unskilled-manual workers 32% attended church, 58% were religious and 65% believed in God. Davie's (1994: 107) concept of 'believing without belonging' being more evident within the working class than the middle class were seen within my sample: more middle class attended church but more working class were 'religious'.

5.2.3 Education

Terminal age of education (TEA) is another indicator of class because occupations associated with higher classes all require education and training.

When investigating the connections between 'believing and belonging' Davie noted a seemingly self-contradictory finding that the more highly educated higher social classes were more religious than the working class, although education has a negative effect on religious beliefs:

…it is at one and the same time true that higher social groupings are on average more inclined to belief and practice than lower ones, and that increased education levels (normally associated with higher social class) have a negative effect on religious belief. (Davie 1994:107)

To gain a picture of the educational level of my respondents they were asked 'at what age did you (or will you) complete your full time education, whether at school or at an institute of higher education'. The exact age was recorded as I felt data would be lost by dividing them into age groups at that stage, although for analysis they were divided into five categories to correspond with those used in the WVS.
Although children now remain in full time education until the age of sixteen some of the respondents had finished their schooling before the school leaving age was raised to sixteen in 1972 (Advisory Centre for Education 1991). Others had always suffered with mental health problems which had interfered with their schooling. 60% had left school at fifteen or sixteen and 40% had continued into further education, some taking government work training courses, but very few had been to university. It has to be noted however that some courses that respondents had undertaken would now be within a university environment, rather than in training colleges or colleges of further education that they attended – the teachers, social worker. The psychiatric service encouraged further education and had good liaison with the local college of further education. Service users could obtain funding for most courses at the college through a charitable association linked to the service. In addition, in many of the work units within the service the service users were able to take NVQ courses.

Service users were asked their occupations, present or past, but these bore little relation to the age at which they finished full-time education. Some completed training schemes but had been unable to find work after completion, or were unable to hold down any sort of work because of their mental illness. Many who had been trained for skilled work had become unskilled manual labourers due to erratic mental health problems.

To contrast my findings with the WVS Great Britain 1990 results, the scores were each condensed into five categories: under 16 years, 16 years, 17-18 years, 19-21 years, 21+years.

Table 5.9: Terminal Education Age, research sample compared with the WVS 1990 – Great Britain/percentages

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>Service Users n=100</th>
<th>WVS n=1484</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>28</td>
<td>43</td>
</tr>
<tr>
<td>16</td>
<td>32</td>
<td>28</td>
</tr>
<tr>
<td>17-18</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>19-21</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>21+</td>
<td>10</td>
<td>NA</td>
</tr>
<tr>
<td>DK, NA</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Source WVS 1990

In the WVS sample 21% were over retirement age and would therefore have finished school before the leaving age was raised to sixteen, which may account for the higher proportion that left school under sixteen years than in my working age sample.

I found that two service users had left school very early: one at 10 years and the other at
11 years because they found school too stressful. The WVS showed no people with a terminal education age over 21 years, this maybe because their question asked the age when the respondent finished ‘school’ rather than ‘education’. Ten service users stated that they continued their education over 21 years; however this included National Vocation Qualifications rather than academic courses. Some of my respondents mentioned that their ill health had disrupted their education and they had gone back to a college of further education to complete their education when they were well enough.

To test Davie’s (1994: 107) proposition that a high education level is associated with lower religious belief and practice I looked at the terminal education age (TEA) for those that did and did not attend church and compared their religiosity.

Table 5.10: Effect of education on religious beliefs and practice

<table>
<thead>
<tr>
<th>Attends Church</th>
<th>Religious status</th>
<th>Count</th>
<th>Under 16 years</th>
<th>16 years</th>
<th>Over 16 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>religious person</td>
<td>Count</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>90%</td>
<td>100%</td>
<td>67%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>not a religious person</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>10%</td>
<td>0%</td>
<td>17%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a convinced atheist</td>
<td>Count</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>0%</td>
<td>0%</td>
<td>8%</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>don't know</td>
<td>Count</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>0%</td>
<td>0%</td>
<td>8%</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Church Attenders</td>
<td>Count</td>
<td>10</td>
<td>7</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>% within Terminal Education Age</td>
<td>Count</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>a religious person</td>
<td>Count</td>
<td>10</td>
<td>12</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>56%</td>
<td>46%</td>
<td>48%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>not a religious person</td>
<td>Count</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>39%</td>
<td>31%</td>
<td>30%</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a convinced atheist</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>5%</td>
<td>0%</td>
<td>7%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>don't know</td>
<td>Count</td>
<td>0</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>% within TEA</td>
<td>0%</td>
<td>23%</td>
<td>15%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Church Non-Attenders</td>
<td>Count</td>
<td>18</td>
<td>26</td>
<td>27</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>% within Terminal Education Age</td>
<td>Count</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Looking at the TEA of the respondents: 36% of the under 16 years, 21% of those aged 16 years and 31% of those over 16 years attended church. Considering the small numbers involved the level of education could not be shown to affect significantly their religious practice.

However, when comparing the TEA of those who described themselves as religious and did or did not attend church it could be seen that the most religious were the TEA under 16 years who attended church (90%) and the least religious were those who continued
education over 16 years and did not attend church (48%).

Looking at those who attended church 90% of those who finished education under 16 years described themselves as religious as opposed to 67% of those whose TEA was over 16 years, and of those who did not attend church 56% TEA under 16 years as opposed to 48% TEA over 16 years said they were religious.

Therefore my sample of people who suffer from enduring mental illness concurred with Davie's proposition that religious beliefs decreased with increased education, but their religious practice was not seen to be affected by their level of education as she found within the general population.

5.3 Social Resources

The next five questions on the Interview Schedule sought information on the social nature of the service users: where they lived, if they knew their neighbours, if they belonged to any clubs and if so which ones, and how they spent their free time.

5.3.1 Accommodation

With the introduction of the government's policy of Care in the Community service users who were once maintained in the long stay hospitals were provided with different levels of support in the community, both in terms of supervision from their 'Key Worker' and provision of supported housing if they required it. Therefore, information about where the service users lived gave an indication of the level of care they required to keep them from becoming ill and needing hospitalisation. Specialised housing associations provided accommodation for people with mental health problems ranging from living in a home with a landlady who provided a very high level of care, to group homes where service users may have their own bed sits and share a kitchen, sitting room and other facilities and have a member of staff visit the home regularly, to living alone with no staff visiting.

In my sample the largest group of people (38%) lived in group-homes, followed by those living with their family (29%), and alone (29%). Very few service users lived with a friend, landlady or as an in-patient in an NHS Trust run home with total care from staff. In percentage terms more women lived with their families M=24% (n=63), F=38% (n=37), and more males lived in group-homes (M=44%, F=27%).
<table>
<thead>
<tr>
<th>Gender</th>
<th>Accommodation</th>
<th>Age group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>18-25</td>
<td>26-34</td>
</tr>
<tr>
<td>Male</td>
<td>Alone</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>With friend</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>In patient</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Landlady</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>Alone</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>With friend</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>9</td>
<td>17</td>
</tr>
</tbody>
</table>

It was interesting to see if there was any pattern of church attendance with living accommodation: 27% of people living alone (n=29); 21% living with families (n=29); 34% of those living in group-homes (n=38); and both respondents living with friends attended a church service. Neither person living with a landlady or as an in-patient attended church. Except for those living with friends living accommodation did not appear to affect religious practice.

Although different factors came into play when arranging accommodation for each service user their place of habitation gave an indication of their mental state and social performance. Those living alone were evidently less incapacitated by their illness than those needing a group-home with full time staff members. However, living with a family gave less of a guide to their level of functioning because family members may be taking the role of the staff within a group home. That no particular accommodation affected religious practice could point to the fact that it was the individual service user who made the decision about religious practice rather than outside influences. One woman overcame all obstacles to be enabled to attend church, and despite her severe mental health problems she arranged for a church member to provide transport because her group home did not want to take her.

5.3.2 ‘Do you know your neighbours?’

When service users were assessed within the service, they were asked if they knew their neighbours to determine their integration with, and ability to cope with, people in society outside the service.

Forty-one service users did not know their neighbours, which showed how very isolated
they were from other people. Some service users had lived in the same house for many years and had had no contact with their neighbours. Some felt unwanted in the community and discriminated against because of their mental illness. Some neighbours had been unhappy about having a house for the mentally ill in their locality, and had campaigned against it because they feared the service users would be violent. Therefore, some service users living in those houses had felt stigmatised and shunned. How much this was reality or paranoia on the part of the service users I was unable to ascertain. However, when people in the WVS 1995 were asked who they would not like to have as neighbours 28% mentioned that they would not like to live next door to people who were 'emotionally unstable'.

When analyzing how many service users in the different types of accommodation knew their neighbours, I found that two-thirds of those who lived alone, seventy-five percent who lived with their families, and all of those living with friends, knew their neighbours. However, of those who lived in mental health facilities – Group Homes and In-Patient Community Homes, 61% did not know their neighbours. This could partially be accounted for by the short time each service user had lived in the home, but given the opposition to the housing of service users in the community they may have been made less welcome than non-mentally ill neighbours.

5.3.3 Belonging to clubs

One of the government's aims when closing the long stay psychiatric hospitals and resettling the patients into the community was, as far as possible, to integrate them with the rest of the population.

In my experience of working within the Service, service users seldom made any friends outside the mental health environment. The friends that they made were from their sheltered work place, from shared supported housing, or from social activities organised by mental health workers. One of the questions on the Service assessment form was 'how many friends have you made outside the service in the past year?', and the answer from my experience was nearly always 'none'.

To find out if my understanding of the situation was correct, and that service users were isolated from contact with people without mental health problems, I asked my sample 'do you belong to any clubs', and to those who replied 'yes' I asked which ones they belonged to. The clubs they belonged to would also indicate if they were active within any religious organisations, as opposed to just attending worship services.
Thirty service users, less than one third, belonged to a total of thirty-six clubs. One service user said he was about to start a drama club, but he admitted that he had been planning to start it for many years.

Out of the thirty-six clubs, eight were run for the benefit of people with mental health problems either by the NHS Trust for its service users, or they were clubs run by other self-help organisations for the wider community: AA, Rethink (used to be called the National Schizophrenia Fellowship: ‘NSF’), or a Mental Health Support Club.

There were seven clubs within churches, including two coffee mornings, a ladies group, a lonely-hearts club, two social clubs and a Bible study group. However, of those seven church-run clubs three were operated specifically for people with mental health problems and learning difficulties. There was a special service for the mentally ill and people with learning difficulties at a church with a tea afterwards, but those who went to this did not categorise it as a ‘club’. A priest had been appointed, who was joint-funded by the NHS Trust and the local diocese of the Church of England, to work part-time within a local church and part-time with service users in the community. She held the three clubs in the church, or in her home adjacent to the church. Two service users had reported that they used to attend some of her clubs but did not like the presence of so many people with learning disabilities so stopped going. In contrast, one service user said that she really liked being able to help them, and it gave her a purpose to her attending the clubs.

While it is difficult to compare my respondents with a general population, the WVS looked at the types of organizations that people belonged to: nearly three times the proportion of people in the general population belonged to sports clubs, and five times as many to art clubs. It is very difficult to make a comparison with ‘church organization’ statistics, because they do not specify what was measured as an ‘organisation’. While 55% of the general population owned affiliation to a denomination and 24% attended church at least once a month, the WVS 1995 reported that 5.7% were active members and 11.3% inactive members of a ‘church organisation’. It appears therefore that the 5.7% active members attended events other than worship services, which could be described as ‘clubs’.
Table 5.12: Membership of clubs, comparing sample of service users with general population WVS 1990/percentages

<table>
<thead>
<tr>
<th>Types of Clubs</th>
<th>Service users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=100</td>
</tr>
<tr>
<td>Church</td>
<td>7</td>
</tr>
<tr>
<td>Sport</td>
<td>6</td>
</tr>
<tr>
<td>Arts</td>
<td>2</td>
</tr>
<tr>
<td>Charity</td>
<td>2</td>
</tr>
<tr>
<td>Environment</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>None</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>n=1484</td>
</tr>
<tr>
<td>Church</td>
<td>17</td>
</tr>
<tr>
<td>Sport</td>
<td>17</td>
</tr>
<tr>
<td>Arts</td>
<td>10</td>
</tr>
<tr>
<td>Charity</td>
<td>9</td>
</tr>
<tr>
<td>Environment</td>
<td>5</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>None</td>
<td>35</td>
</tr>
</tbody>
</table>

Note: Some service users belonged to more than one type of club.

Although comparisons are hard to make it is evident that the mentally ill belong to far fewer clubs/organisations than the general population. As with housing this could be because they do not feel welcomed by the community. Even within churches many people felt stigmatised by their illness and not made welcome within the congregations, therefore it was understandable that clubs not organised around an ethos of care would not encourage mentally ill people to participate in their activities. The reverse of this situation is the service users’ reluctance to join clubs, sometimes through lethargy caused by the illness and the prescribed medication.

Table 5.13: Membership of clubs by age and gender (n = 100)

<table>
<thead>
<tr>
<th>Age of respondents</th>
<th>Belong to clubs</th>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
<td>Male n=63</td>
<td>Female n=37</td>
</tr>
<tr>
<td>18-25 years</td>
<td>3</td>
<td>0</td>
<td>3 (33%)</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1</td>
<td>6 (66%)</td>
</tr>
<tr>
<td>26-34 years</td>
<td>2</td>
<td>1</td>
<td>3 (18%)</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>3</td>
<td>14 (82%)</td>
</tr>
<tr>
<td>35-44 years</td>
<td>7</td>
<td>2</td>
<td>9 (36%)</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>8</td>
<td>16 (64%)</td>
</tr>
<tr>
<td>45-65 years</td>
<td>10</td>
<td>9</td>
<td>19 (39%)</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>13</td>
<td>30 (61%)</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>12</td>
<td>34 (34%)</td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>25</td>
<td>66 (66%)</td>
</tr>
<tr>
<td>All</td>
<td>63</td>
<td>37</td>
<td>100%</td>
</tr>
</tbody>
</table>

When looking to see if there was a difference in membership of clubs by gender it was noted that a slightly higher proportion of men than women reported belonging to clubs: 35% of men (n = 63) and 32% of women (n = 37). This may be because of the popularity of sports clubs which tends to be more male orientated. Except in the age group of 26-34 year olds where only 18% belonged to clubs, around a third of the
respondents belonged to clubs with a slight increase with age.

5.3.4 Free time

The service users were asked how they spent their free time. Only 7% of the sample was employed full-time and of the 57% of service users working in sheltered work, many were on a part-time programme. The question was left open to the respondent to define ‘free time’.

The responses have been summarized under five headings:

1. **Entertainment** covered watching the television, listening to music, visiting the cinema, watching videos and listening to the radio.

2. **Socializing** covered visiting the pub, visiting family and friends, going to nightclubs, clubbing with friends, looking after grandchildren and nephew, church meetings, going to an unspecified ‘schizophrenia club’, voluntary work, fundraising, teaching First Aid.

3. **Exercise** included walking, bowling, canoeing, weight training, swimming, fitness, jogging, aerobics, playing football, and fishing.

4. **Hobbies** covered sewing and knitting, keeping cats and dogs, ‘playing on the computer’ and internet, acting, jumble sales, gardening, learning shorthand, drawing, reading, watching cricket, writing poetry, crossword puzzles, playing the classical guitar, going to air shows, praying and reading the Bible.

5. **Housework** included housework, doing chores, shopping and cooking, washing, and cleaning.


Most service users mentioned several ways of spending their free time. 64% engaged in ‘entertainment’, 32% ‘socialized’, 15% did some form of ‘exercise’, 52% had ‘hobbies’, and 4% mentioned ‘other’ ways of spending their free time.

The respondents had much more ‘free time’ than the general population of a comparable age, and the use they made of it was marked by the solitary nature of most activities. The 64% who spent time on ‘entertainment’ were mostly alone, and although 32% did ‘socialize’ this was predominantly with family, or friends within the mental health services. Even the ‘hobbies’ were mainly solitary. The responses under the category ‘other’ expressed some of the disruption and pain that mental illness had brought to the lives of some of the service users.
Table 5.14: Use of free time by age and gender (n = M 64, W 37)

<table>
<thead>
<tr>
<th>Age</th>
<th>Entertainment</th>
<th>Socialize</th>
<th>Exercise</th>
<th>Hobbies</th>
<th>Housework</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M  F</td>
<td>M  F</td>
<td>M  F</td>
<td>M  F</td>
<td>M  F</td>
<td>M  F</td>
</tr>
<tr>
<td>18-25</td>
<td>8  1</td>
<td>2  1</td>
<td>3  1</td>
<td>3  1</td>
<td>1  0</td>
<td>1  0</td>
</tr>
<tr>
<td>26-34</td>
<td>10 4</td>
<td>3  2</td>
<td>1  2</td>
<td>7  3</td>
<td>1  0</td>
<td>1  0</td>
</tr>
<tr>
<td>35-44</td>
<td>10 7</td>
<td>8  8</td>
<td>3  2</td>
<td>7  6</td>
<td>1  6</td>
<td>1  0</td>
</tr>
<tr>
<td>45-65</td>
<td>17 12</td>
<td>5  9</td>
<td>8  3</td>
<td>12 11</td>
<td>1  1</td>
<td>1  2</td>
</tr>
<tr>
<td>Total</td>
<td>45 24</td>
<td>18 20</td>
<td>15 8</td>
<td>29 21</td>
<td>5  7</td>
<td>4  2</td>
</tr>
</tbody>
</table>

Note. Most respondents mentioned more than one way of spending their free time.

5.3.5 Summary

The sample consisted of 100 people with enduring mental health problems in one Psychiatric Service. There were a higher proportion of men than in the general population and of service users as a whole. The largest group of respondents was in the age range of 45-65 years. Both these findings were partly due to the nature of the Service.

Very few were found to be in open employment due to their mental illness, but a large proportion was in part time employment in ‘sheltered work’ provided by the NHS Trust as part of their treatment. Their terminal age of education showed a similar pattern to the general population of the WVS, except that fewer had left school before 16 years and many more had extended their TEA to over the age of 21 years.

They tended to be isolated from the community and confined their friendships to family, and friends within the Mental Health Service. They belonged to fewer outside organizations than the general population and their free time activities tended to be solitary.

The second part of this analysis will look at the religious component of the service users’ lives, and again compare them with the general population.

5.4 Religion in the Lives of the Respondents

The British Social Attitudes Survey 2001 states that:

For some people religion is an important part of their lives – it can provide contact with others as well as participation in the local community. However in 1999 almost half of all adults aged 18 and over in Great Britain who said that they belonged to a religion or were brought up in a religion said that they never, or practically never, attended a religious service. 13% of women and 10% of men attended a religious service at least once a week. (British Social Attitudes 2001)

The next set of questions formed the main focus of the study. Service users were asked
about their religious experiences, attendance at religious institutions, spiritual interests, religious upbringing, their views on God, if they prayed or meditated, and if they read their horoscope.

Studies have shown that religious experiences are most likely to be reported by women, older people, well educated, middle class and from small town areas (Hay 1982:124). Hay also found that diverse religious groups, and those who affirmed no religious allegiance, recorded different levels of occurrences of religious experience. He noted the fact that owning membership of a church gave no indication of religious commitment or report of experience. However, being brought up within a religious framework may give a religious understanding and explanation to a strange experience. I felt it imperative therefore to gain a wide understanding of the part that religion played in the lives of my sample.

5.4.1 Religious Experience

In one of the early pilot study interviews a service user said that I should ask people if they felt that they had been ‘in the presence of God’. Subsequent respondents thought it important knowledge so it was included in the Interview Schedule. Over half the sample had felt ‘in the presence of God’, but more women than men agreed that they had – 63% of the women (n = 37) and 48% of the men (n = 63).

The respondents were asked ‘Have you ever had an experience that you might call ‘spiritual’ or ‘religious’?’ This question was pivotal to the research, and provided one of the criteria for selecting the subjects for the second stage in depth interviews.

The concept or interpretation of the word ‘experience’ was a problem for some service users. I felt that the important point of the question was to find out if the service users felt that they had had a ‘religious experience’, not whether I described their experience as being ‘religious’. If a respondent asked me what was meant by the word, I reflected back what they had described to me and asked if they thought it was a ‘religious experience’. This may have led to different interpretations, but any experience is subjective by nature and a spiritual one is very personal. The only help that I offered was to state that a ‘religious’ or ‘spiritual experience’ was something out of the ordinary. Of my sample 67% affirmed that they had had a ‘religious experience’.

Kroll et al (1989) examined 52 psychiatric in-patients in Minnesota, 19 men and 33 women. He reported that 46% of the patients (68% of the men and 33% of the females) described having had a ‘religious experience’. Experiences that they noted were: ‘God
or spirits communicate with me’, ‘have a mission’, ‘speak in tongues’, ‘God speaks through me’, ‘God or the Devil makes me do things’, ‘have power to heal’, ‘pray daily’. He compared his finding to Greeley’s study of a general population of 1,460 respondents in the US in 1973 who found 35% reported a religious experience (quoted in: Kroll and Sheehan 1989:69-70).

Although the Mental Health Foundation study (McKerrow and Faulkner 1997) found no difference by age or gender in those who expressed religious interests or needs and those who did not, more women attend church than men and Davie (1994: 117) declared them to be more religious than men. I decided therefore to see if a higher proportion of women had religious experiences. Indeed, in my sample this was the case: 28 women (76%) and 39 (62%) men reported that they had had a religious or spiritual experience.

The highest proportion of respondents who experienced a strange phenomenon that they described as religious were aged 26-34 years (88%, n = 17), and the lowest was the youngest respondents 22% aged 18-25 years (n=9). There did not appear to be a consistent trend; 72% aged 35-44 years (n=25) and 65% those aged 45-64 years (n=49) recounted having had a religious experience.

To see if education had an effect I looked at the terminal age of education, and found that the highest proportion of those who had had a religious experience were those who had most years of education: 80% of those who finished at 22-28 years; 62% at 17-21 years; 67% at 16 years; 71% at 15 years; and 57% at 10-14 years. However, the numbers were small, and within this sample the fact that some respondents were still receiving education over the age of twenty-one did not necessarily intimate intellectual prowess because some services users were undertaking National Vocational Qualification courses which they regarded as further education.

There was very little difference in occurrence between manual and non-manual workers: 73% of professional and skilled non-manual; and 70% of skilled manual, semi-skilled manual and unskilled manual, had had a religious experience.

77% of those who had a religious experience described themselves as religious, which was understandable. However, 9% of those who reported a religious experience were not religious, 5% were atheists and 9% did not know how to describe their religiosity.

Of the thirty-eight men and twenty-nine women who had had a religious experience three men and one woman would not describe them to me. One said “the experience was personal”, another “the experience was spiritual but I don’t want to talk about it”,

105
another "an experience I have everyday and I don’t want to talk about it", and one woman was reticent throughout the whole interview and simply declined to give any explanation of her refusal. The reported experiences will be analysed in Chapter 4.

5.4.2 Measuring Religious Identification

I was interested to know how the respondents would define their religious status. Some of the committed Christians did not like the term ‘religious’ as they felt that it had some unpleasant connotations. As Sharon expressed in the recorded interview:

'Religious' is a word that people don't like very much. It's sort of, I don't know, it's...We like saying we are Christians or whatever. I don't know. Maybe religious goes with pious; maybe they don't think it is very sincere. Sort of praying and pretending. Perhaps they think it is all for show. Sharon (RI:73)³

I had to explain that it was necessary to follow the terminology used in the WVS and the EVS in order to compare the samples.

Respondents were first asked to identify themselves as either ‘a religious person’, ‘not a religious person’, ‘a convinced atheist’, or ‘don’t know’. The question was taken from the WVS 1990 to facilitate comparison with the general population.

There was a noticeably difference between the sexes: 78% of the women described themselves as ‘religious’ but fewer than half the men; 38% of the men but only 5% of the women declared they were ‘not religious’; nearly twice as many men than women were ‘atheists’; but nearly equal numbers described themselves as ‘don’t know’.

Age affected the respondents’ self-description of their religious status: those in the highest age bracket of 45-65 years were three times more likely to describe themselves as ‘religious’ as the youngest age group of 18-25 years. However, in my sample the 26-34 year olds were slightly more religious (59%) than the 35-44 year old (56%).

³ RI signifies that the quotation is taken from the second, recorded interview. The number signifies the line in the respondent’s file in the MAXqda computer analysis programme.
Table 5.15: Religious status by age and gender/percentages

<table>
<thead>
<tr>
<th>Gender</th>
<th>Religious status</th>
<th>Count</th>
<th>18-25</th>
<th>26-34</th>
<th>35-44</th>
<th>45-65</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>religious person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>25%</td>
<td>54%</td>
<td>53%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>Male</td>
<td>not a religious person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>50%</td>
<td>23%</td>
<td>27%</td>
<td>48%</td>
<td>38%</td>
</tr>
<tr>
<td>Male</td>
<td>a convinced atheist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>0%</td>
<td>8%</td>
<td>13%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>Male</td>
<td>don't know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>25%</td>
<td>15%</td>
<td>7%</td>
<td>4%</td>
<td>10%</td>
</tr>
<tr>
<td>Female</td>
<td>religious person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>0%</td>
<td>75%</td>
<td>60%</td>
<td>91%</td>
<td>78%</td>
</tr>
<tr>
<td>Female</td>
<td>not a religious person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>Female</td>
<td>a convinced atheist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>100%</td>
<td>0%</td>
<td>.0%</td>
<td>.0%</td>
<td>3%</td>
</tr>
<tr>
<td>Female</td>
<td>don't know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td></td>
<td>0%</td>
<td>25%</td>
<td>20%</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Total Female</td>
<td></td>
<td>8</td>
<td>13</td>
<td>15</td>
<td>27</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>% within Age of male service users</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

I wanted to see which group was the most religious, to see if my sample matched previous research which found women and older people were more religious than men and young people (Bruce 1995; Davie 1994).

My sample did show the same finding: women in the highest age group were the most religious at 91%. It was interesting to see if my females were more or less religious than the general population.

When comparing my sample with the general population the females were slightly more religious than WVS sample, but the males were less religious. The same proportions in both samples were atheists but many more respondents in my sample were ‘don’t know’. Service users are not normally asked about religious matters and those who were not religious would probably not have thought about such issues. They are a vulnerable group and it was understandable that so many would be cautiously non-committal.
Table 5.16: Religious status, research sample compared with the WVS 1990 – Great Britain/percentages.

<table>
<thead>
<tr>
<th>Religious status</th>
<th>Service users</th>
<th>WVS 1990</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male n=63</td>
<td>Female n=37</td>
</tr>
<tr>
<td>a religious person</td>
<td>59</td>
<td>78</td>
</tr>
<tr>
<td>not a religious person</td>
<td>26</td>
<td>5</td>
</tr>
<tr>
<td>a convinced atheist</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>don't know</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source WVS 1995

When comparing my sample with another American sample, Fitchett et al (1997) found that 80% of his US psychiatric in-patients and 86% US medical/surgical patients considered themselves to be ‘a spiritual or religious person’, in comparison to 59% of my sample. It was understandable that both his sample populations should be more religious because North America is notably more religious than England. It is a problem when making comparisons with other research about the religious nature of people with mental health problems that most research has taken place in the US which has a fundamentally different attitude to religion.

In Great Britain women saw themselves as more religious than the men both in my psychiatric sample and in the general population. It was necessary to see how their beliefs were translated into practice, to see if my sample confirmed Davie’s notion of ‘believing without belonging’ (1994).

5.4.3 Religious Practice

The respondents were asked several questions about their religious practice: ‘do you attend any services of a religious group?’; if yes ‘which one?’; ‘apart from weddings, funerals and christenings, how often do you attend?’. To assess how many respondents had changed their religious practice over the years, those who did not attend a service at present were asked if they had done so in the past. If they had attended a service they were asked ‘which one?’, ‘how long ago had they last attended?’, and ‘why they had ceased attending a place of worship?’.

Both Bruce and Davie reported that women and older people were more religious and attend religious services more than men and younger people. This was true in my sample: only 29% of the total sample attended a place of worship, and of those 35% of the female respondents attended as opposed to 25% of the male respondents.
Table 5.17: Religious practice by gender

<table>
<thead>
<tr>
<th></th>
<th>Attend religious group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>male</td>
<td>Count</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>16</td>
<td>47</td>
</tr>
<tr>
<td>female</td>
<td>Count</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>29</td>
<td>71</td>
</tr>
<tr>
<td>% within Attend religious group</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Looking at my sample the age of my respondents who attended a service showed the same pattern that had been noted by Bruce and Davie in the general population. It was notable that with advancing years progressively more people attended a religious service: whereas only 11% of the 18-25 year olds attended a service, 37% of those in the age range of 45-65 years of age did.

Table 5.18: Religious practice by age

<table>
<thead>
<tr>
<th>Attend Religious Group</th>
<th>Age of Patient</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-25</td>
<td>26-34</td>
<td>35-44</td>
<td>45-65</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within Age of patient</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>18</td>
<td>29</td>
</tr>
<tr>
<td>no</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within Age of patient</td>
<td>8</td>
<td>15</td>
<td>17</td>
<td>31</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within Age of patient</td>
<td>9</td>
<td>17</td>
<td>25</td>
<td>49</td>
<td>100</td>
</tr>
<tr>
<td>% of Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

Women were also more frequent in their religious practice than men. Analyzing the service users who said that they attended religious services showed that: most attended once a week (16% of the women and 10% of the men); 14% of the women and 2% of the men attended church more than once a week; 5% of the women and 10% of the men once a month; and 5% of the women and 19% of the men said they only attended at Christmas or Easter.
Table 5.19: Frequency of religious practice by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>male</td>
</tr>
<tr>
<td>more than once a week</td>
<td>1</td>
</tr>
<tr>
<td>% within Gender</td>
<td>2%</td>
</tr>
<tr>
<td>once a week</td>
<td>6</td>
</tr>
<tr>
<td>% within Gender</td>
<td>10%</td>
</tr>
<tr>
<td>once a month</td>
<td>6</td>
</tr>
<tr>
<td>% within Gender</td>
<td>10%</td>
</tr>
<tr>
<td>Christmas/Easter</td>
<td>12</td>
</tr>
<tr>
<td>% within Gender</td>
<td>19%</td>
</tr>
<tr>
<td>Once a year</td>
<td>1</td>
</tr>
<tr>
<td>% within Gender</td>
<td>2%</td>
</tr>
<tr>
<td>never/practically never</td>
<td>37</td>
</tr>
<tr>
<td>% within Gender</td>
<td>59%</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
</tr>
<tr>
<td>% within Gender</td>
<td>100%</td>
</tr>
</tbody>
</table>

There was some similarity between my sample and the general population in terms of their religious practice: 26% of the service users and 24% of the general population attended a service at least once a month, and 14% of my respondents and 12% of the general population attended church at Christmas and Easter. However, more of the service users said that they never attended a religious service.

Table 5.20: Attendance at religious services, comparing service users with WVS 1990 Great Britain/percentages.

<table>
<thead>
<tr>
<th>Attend how often</th>
<th>Service users n=100</th>
<th>WVS 1990 n=1484</th>
</tr>
</thead>
<tbody>
<tr>
<td>more than once a week</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>once a week</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>once a month</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Christmas/Easter</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Once a year</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>never/practically never</td>
<td>58</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source WVS 1995

Of the fifty-nine service users who had described themselves as ‘religious’ only twenty-one attended services at least once a month. Five other service users attended at least once a month: three respondents who were ‘not religious’, one ‘don’t know’, and one ‘convinced atheist’. The three service users who described themselves as ‘not religious’ were all middle aged, well educated, who had considered deeply their spiritual beliefs and although they went to church would not classify themselves as ‘religious’. Two attended the services provided for the mentally ill. The service user who described...
himself as ‘a convinced atheist’ was someone who had undergone a powerful charismatic conversion experience and for whom religion had been very traumatic. Although he had very ambivalent feelings about his beliefs and now adamantly rejected them in his search for mental health, he still went to the Roman Catholic Church with his parents. The ‘don’t know’ respondent was a young man who went to the Church of England also with his parents.

Although the denomination that patients attended was not important except for comparison with other populations, I wanted to find out how many people used the church services provided by the Trust, in partnership with the local Church of England diocese, specifically for people with mental illness and learning disabilities. Asking which denomination they attended provided this information, because any respondent who attended a Church of England was asked to specify which one. Seven (four male and three female) of the twenty-six service users who attended services at least once a month only attended services in the church where special provision was made for disabled people.

To make a comparison with the general population the religious practice of the service users was contrasted with the WVS figures.

Table 5.21: Religious denomination of those who reported attending a religious service, compared to the general population/percentages

<table>
<thead>
<tr>
<th>Religious Denomination</th>
<th>Service users n=100</th>
<th>WVS 1995 n=1484</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roman Catholic</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Church of England</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>C of E - Special</td>
<td>7</td>
<td>NA</td>
</tr>
<tr>
<td>Church of England - All</td>
<td>14</td>
<td>NA</td>
</tr>
<tr>
<td>Non Conformist</td>
<td>8</td>
<td>NA</td>
</tr>
<tr>
<td>All Protestant (C of E +NC)</td>
<td>22</td>
<td>37</td>
</tr>
<tr>
<td>Other faiths</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Non-attenders</td>
<td>71</td>
<td>43</td>
</tr>
</tbody>
</table>

Source WVS 1995

Bearing in mind that the numbers in my sample were small, the percentage of Roman Catholics was only half that of the general population, and the Protestants slightly more than a half. The interesting point to note was that there were more than four times as many people from other faiths in the general population, which was no doubt due to the location of my research sample not because the religious mentally ill chose Christianity.

As has been stated the locality was a small town in the South East of England with a predominance of white Caucasians who had been socialised within a Christians culture, and therefore if they were religious they were likely to be Christians.
Table 5.22: Age of service users attending services by denomination

<table>
<thead>
<tr>
<th>Denomination</th>
<th>Age of service user</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-25</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>Count</td>
</tr>
<tr>
<td>% within Age</td>
<td>0%</td>
</tr>
<tr>
<td>Church of England</td>
<td>Count</td>
</tr>
<tr>
<td>% within Age</td>
<td>11%</td>
</tr>
<tr>
<td>Free Church / Non Conformist</td>
<td>Count</td>
</tr>
<tr>
<td>% within Age</td>
<td>0%</td>
</tr>
<tr>
<td>Hindu</td>
<td>Count</td>
</tr>
<tr>
<td>% within Age</td>
<td>0%</td>
</tr>
<tr>
<td>other</td>
<td>Count</td>
</tr>
<tr>
<td>% within Age</td>
<td>0%</td>
</tr>
<tr>
<td>None</td>
<td>Count</td>
</tr>
<tr>
<td>% within Age</td>
<td>88.9%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
</tr>
<tr>
<td>% within Age</td>
<td>100%</td>
</tr>
</tbody>
</table>

Looking at the patterns of denominational affiliation by age all the Roman Catholics were over 35 years of age, and all the 18-25 years olds who attended church were Church of England. As has been noted before, church attendance increases with age and this was true in this sample.

5.4.4 Beliefs

An important question that lay at the foundation of this research was, ‘why do people with mental illness have higher than average religious interests and needs?’ (McKerrow and Faulkner 1997). Looking at the respondents’ religious beliefs was therefore important, in order to uncover what they found in religion that made it more attractive to mentally ill people than to the general population. In order to make comparisons with both the groups, service users were asked questions from the WVS.

The respondents were asked the WVS question, ‘Do you get comfort and strength from religion or not?’, and just over half said that they did, which was slightly more than the general population (46%).

Another question asked ‘how important is God in your life?’. It was interesting that service users who had hesitated and been tentative about answering other questions found no difficulty in saying on the scale of 1-10 what they felt about God.

Most service users had clear views on whether ‘God was very unimportant’ (20), or ‘very important’ (30) in their lives, or they did not hold strong views and circled number five ‘neither important nor unimportant’ (14).
Table 5.23: The importance of God in service user’s lives, compared to World Value Survey 1990/percentages

<table>
<thead>
<tr>
<th>Importance of God</th>
<th>Point on scale</th>
<th>Service users n=100</th>
<th>WVS 1990 n=1484</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td>1</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Neither important nor unimportant</td>
<td>5</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Very Important</td>
<td>10</td>
<td>30</td>
<td>17</td>
</tr>
</tbody>
</table>

Source WVS 1990

Overall God was important to 51% (points 6-10) of the service users and unimportant to 35% (points 1-4). God appeared to be very important to a higher proportion of the service users than the general population. 42% of the service users scored 8-10 on the scale compared to 29% of the general population. Half the 35-44 year olds said that ‘God was important’, and men and women were similar in their responses. However, there was a difference in the 45-60 years age group, where 43% of the men and 67% of the women said that ‘God was important in their lives’ scoring 8-10 on the scale. 77% of the service users aged 18-34 years circled ‘1-5’ showing that ‘God was not important in the lives’, with little difference by gender.

To explore the nature of the service users’ spirituality they were asked whether or not they believed in a ‘personal god’, or a ‘spirit or life force’. Davie looked at the common religious beliefs that she reviewed in England and agreed with Abercrombie when he said:

> We have some evidence that for those people who do not go to church yet say that they are religious and pray often, religious belief has moved quite far from the orthodox church position and is really much closer to what would normally be called superstition. (Abercrombie et al. 1970 quoted in: Davie 1994:79)

Many of the service users could identify more easily with a ‘life force’ rather than the monotheistic God of the Christian faith, which was similar within the general population. However, a third of the service users believed that there was a personal God, which was nearly the same proportion as within the general population.
Table 5.24: Personal Statement of Belief/percentages

<table>
<thead>
<tr>
<th>Statement</th>
<th>Service users</th>
<th>EVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a personal God</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>There is some sort of life force</td>
<td>46</td>
<td>41</td>
</tr>
<tr>
<td>I don't really know what to think</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>I don't really think there is any sort of spirit, God or life force</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source EVS 1990

The noticeable difference in the two samples was the way they described themselves when they did not believe in some sort of God/life force: the service users were more likely to say that they ‘didn’t know’ whereas the general population had ‘other’ unspecified beliefs.

Most of the people who believed in a personal God described themselves as ‘religious’, which was understandable, whereas people who believed in a ‘life force’ were less likely to described themselves as ‘religious’ (57%) - 26% described themselves as ‘not religious, 7% as atheists and 10% ‘didn’t know’.

I looked to see if there was an age and gender bias as there was in the self-description of religious status: i.e. older women were the most religious.

Table 5.25: Percentages within age groups of personal beliefs (n = m 63, w 37)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Personal belief</th>
<th>18-25 years</th>
<th>26-34 years</th>
<th>35-44 years</th>
<th>45-65 years</th>
<th>Total within all ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>There is a personal God</td>
<td>25</td>
<td>31</td>
<td>33</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>There is some sort of life force</td>
<td>38</td>
<td>54</td>
<td>33</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>I don't really know what to think</td>
<td>12</td>
<td>7</td>
<td>13</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>I don't really think there is any sort of spirit, God or life force</td>
<td>12</td>
<td>8</td>
<td>13</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>13</td>
<td>0</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>% within Age of patient</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Female</td>
<td>There is a personal God</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>There is some sort of life force</td>
<td>100</td>
<td>75</td>
<td>50</td>
<td>40</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>I don't really know what to think</td>
<td>0</td>
<td>25</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>I don't really think there is any sort of spirit, God or life force</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>% within Age of patient</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

The men aged 45-64 years were more likely to believe in a ‘life force’ than in a ‘personal God’ whereas the women of the same age believed more in ‘God’ than in a ‘life force’. There was a significant difference in the beliefs of those aged 18-34 years:
more men and all the women believed in a ‘life force’ rather than ‘a personal God’. However, in all age groups and in both sexes the service users were more likely than the general population to believe in some sort of personal God or life force.

Most of the respondents believed in a spiritual realm and for a third this was a ‘personal God’: (30% of the men and 40% of the women).

They were asked about specific elements of their beliefs using questions asked by the WVS so a comparison could be made with the general population.

Table 5.26: Service users’ beliefs, compared to British General Population/percentages

<table>
<thead>
<tr>
<th>Belief in</th>
<th>Service Users N=100</th>
<th>WVS 1990 N=1484</th>
</tr>
</thead>
<tbody>
<tr>
<td>God</td>
<td>71</td>
<td>72</td>
</tr>
<tr>
<td>Life after death</td>
<td>59</td>
<td>44</td>
</tr>
<tr>
<td>A soul</td>
<td>79</td>
<td>64</td>
</tr>
<tr>
<td>The Devil</td>
<td>62</td>
<td>32</td>
</tr>
<tr>
<td>Hell</td>
<td>52</td>
<td>26</td>
</tr>
<tr>
<td>Heaven</td>
<td>70</td>
<td>55</td>
</tr>
<tr>
<td>Sin</td>
<td>80</td>
<td>69</td>
</tr>
<tr>
<td>Resurrection from the dead</td>
<td>52</td>
<td>N/A</td>
</tr>
<tr>
<td>Re-incarnation</td>
<td>35</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source World Value Surveys 1990

The service users were very similar to the normal population on one issue, a belief in God. A much higher proportion of the service users compared to the general population believed in ‘life after death’ (59% compared to 44%), ‘a soul’ (79% compared to 64%), and ‘heaven’ (70% compared to 55%). However, twice as many service users believed in hell and the Devil, and several service users were interested in devil worship and issues to do with the occult. Several respondents had commented that ‘hell is here on earth’, as for them their mental illness brought great suffering. Maybe the converse was true that they desired an escape from their suffering in the next life, and therefore put their trust in a having a soul, which would go into an after life and be rewarded in heaven. Some researchers have commented that depressed psychiatric patients feel guilty because they had sinned while others have found the reverse. In my sample 80% of the service users believed in ‘sin’ compared to 69% of the general population, without saying whether they felt that they had sinned personally.
Table 5.27: Belief in the Devil by gender and age

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age of patient</th>
<th>Belief in Devil</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-25 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=9</td>
<td>yes</td>
</tr>
<tr>
<td>male</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>26-34 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=17</td>
<td>yes</td>
</tr>
<tr>
<td>male</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>35-44 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=25</td>
<td>yes</td>
</tr>
<tr>
<td>male</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>45-65 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=49</td>
<td>yes</td>
</tr>
<tr>
<td>male</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>female</td>
<td>Belief in Devil</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td>no</td>
<td>0</td>
</tr>
<tr>
<td>female</td>
<td>yes</td>
<td>1</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>female</td>
<td>18-25 years</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td>n=9</td>
<td>yes</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>female</td>
<td>26-34 years</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td>n=17</td>
<td>yes</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>female</td>
<td>35-44 years</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td>n=25</td>
<td>yes</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>female</td>
<td>45-65 years</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td>n=49</td>
<td>yes</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>Belief in Devil</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>no</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>yes</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>63</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37</td>
</tr>
</tbody>
</table>

Apart from both 65 years old females, the age group with the highest belief in the devil was 18-25 year olds (67%). It could be surmised that the reason for these two age groups having the highest belief in the devil would be for different reasons: the older due to a Christian education in an age when notions of God and the Devil were taught to children and the younger because of present cultural interest in the occult. Belief in the Devil in the other age groups was above 60%, which is surprising in an age of secularization.

5.4.5 Superstitions

It was possible that the higher than average religious interests and needs of the service users was due to their seeking security when enmeshed in the chaotic world of their mental illness. Hargrove believed that ‘superstitions’ came under the category of ‘myth and ritual’ which “provide the security of the familiar in the face of the potential chaos of the unknown” (1979: 33). Martin (1967) argued that the differentials associated with other beliefs did not hold true when looking at superstitions: the young working class males were more likely to be superstitious than older, middle class females.

To investigate the role that ‘superstition’ performed in the lives of the service users several questions were asked: did they have any ‘holy objects’, and/or possessed a ‘mascot or talisman’, or any ‘lucky charm’. They were also asked if they thought that the ‘holy objects’ could ‘protect or help people’ and if the lucky charms could ‘help or protect’ themselves.

Over half the sample had a ‘holy object’: 69% of the women and 51% of the men. They mentioned that they owned crosses, Bibles, holy pictures, and holy water. Half the women and over half the men did not believe that the objects could protect them, which begged the question ‘why did they own them?’ – they may have felt embarrassed admitting to me that they believed that an inanimate object could protect them. Only
one fifth possessed lucky charms, and less than a quarter of all the service users thought that lucky charms could protect them from harm. There was little difference between the genders. In the British Social Attitudes 1991 (1991) 22% believed that 'good luck charms do bring good luck', so that my respondents were in line with the general public's beliefs.

Reading horoscopes is part of the English way of life for many people now and they are to be found in most magazines and newspapers and on the Internet. I asked my sample if they read their horoscope and how often, and if they believed that the horoscope could affect their lives. Of all the questions that the respondents were asked, I felt that these two probably underestimated the true figures.

21% of the service users reported that they read their horoscope at least once a week, but 44% never read it. Many people reacted to the question: some of those who said that they read their horoscope were embarrassed by the fact, and several respondents said that as Christians they wanted nothing to do with them. 31% of the respondents believed that it had some effect in their lives. The WVS 1995 looked at how many people believed that 'a person's star sign at birth, or horoscope, can affect the course of their future'. In Great Britain 28% replied 'definitely' and 'probably true', 64% 'probably' and 'definitely false', and 9% 'I can't choose' and 'no answer'. Although an exact comparison could not be made between the two samples because the questions asked of the two groups were not the same, they were both enquiring about believing that horoscopes could affect someone now or in the future and both samples had a similar response rate: 31% service users and 28% general public.

It appeared that the service users did not turn to astrology for their security in the same way that they turned to mainstream religion. They were more religious than the general population but no more likely to consult their stars for guidance and protection.

5.4.6 Religious Needs and Resources

In Fitchett et al's US study comparing medical/surgical and psychiatric patients they found that they both reported having religious needs and resources: 76% of the physically ill and 88% of the mentally ill reported having three or more religious needs during their hospitalisation. They saw 

religious belief needs
as: 'knowing God's presence', 'purpose and meaning in life', relief from the fear of death', religious practice needs as: 'prayer', 'sacraments', 'communion', and religious social support needs as: 'care and support from another', 'chaplain visit and pray', 'visit from a
clergyperson'. When they asked their psychiatric in-patients if they had any additional religious needs, the needs they mentioned included ‘courage’, ‘to be happy’, need concentration’, ‘someone to talk to’, ‘how to live with some of the things I have done’, ‘relief from fear of ECT’, ‘God answering my prayer’ (1997:323). I did not ask my sample at this stage if they had other religious needs and resources, but did so in the second stage in-depth interviews.

5.4.7 Prayer

Prayer and meditation is at the heart of many religious practices, both public and private. Davie (1994) contended that women were more likely to believe in the importance of private prayer and to practise it. To assess how important private prayer was for the patients they were asked if they ever took time to ‘pray, meditate or contemplate or something like that’, and if so how often outside of a religious service. 25% of men and 40% of women prayed often, while 48% of men and 16% of women said they never prayed. 10% of men and 16% of women prayed in a crisis.

Table 5.28: Frequency of prayer by service users/ percentage within gender

<table>
<thead>
<tr>
<th>How often pray</th>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>male</td>
<td>female</td>
</tr>
<tr>
<td>often</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>sometimes</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>hardly ever</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>only in times of crisis</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>never</td>
<td>48</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Davie’s findings were confirmed in my sample. Not only did significantly more women than men ‘pray often’, three times as many men as women said that they ‘never prayed’. Women were also more likely to turn to prayer in a crisis.

5.4.8 Relationship to Congregations

From the data my sample appeared very isolated from the general population and I wondered how many were assimilated into the church they attended. Of the twenty-six service users who attended a religious service at least once a month eighteen knew ‘almost all’ or ‘many’ in the congregation, six knew between one and five people, and two knew nobody at all. Within the eighteen who knew many in the congregation seven service users attended the special service where everyone was known to each other and two were from very small sects, so it was to be expected that they should know one
another. One was a Hindu and one a Jehovah’s Witness, who culturally interact more with one another within the congregation than in the mainline churches. Although the numbers were very small, none of the Roman Catholics knew more than one to five people in the congregation, and only two Church of England respondents knew a good number within their congregation. There were no figures to compare with a general population so it was not possible to know if congregations were generally unfriendly or whether they were stigmatising the service users. On the other hand the congregations may have been welcoming but the service users were unable or unwilling to respond.

Table 5.29: Know people within the congregation by denomination and attendance

<table>
<thead>
<tr>
<th>Know people in congregation</th>
<th>Roman Catholic</th>
<th>Church of England</th>
<th>Service Users’ Church</th>
<th>Free Church / Non Conformist</th>
<th>other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost All</td>
<td>Attend how often</td>
<td>more than once a week</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>once a week</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>once a month</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Many</td>
<td>Attend how often</td>
<td>more than once a week</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>once a week</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>once a month</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>A Few (1-5)</td>
<td>Attend how often</td>
<td>once a week</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>once a month</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>None</td>
<td>Attend how often</td>
<td>once a week</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>once a month</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total number of service users</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

Fitchett et al (1997) found that the psychiatric in-patients and the medical/surgical patients in his study both knew a similar number of people in their congregations.

Table 5.30: People known personally in the congregation, English compared to US samples/percentage

<table>
<thead>
<tr>
<th>Number of people known personally in the congregation</th>
<th>English Service Users N=26</th>
<th>US Psychiatric In-Patients N=51</th>
<th>US Medical/Surgical Patients N=50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost all</td>
<td>27</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Many</td>
<td>31</td>
<td>39</td>
<td>32</td>
</tr>
<tr>
<td>A few (1-5)</td>
<td>23</td>
<td>28</td>
<td>34</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>17</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: Fitchett et al 1997

Nearly twice as many English service users as US psychiatric patients and more than half of the US medical patients knew almost their entire congregation. However, the
English sample contained nine special cases: seven had their own service, two were from small sects so comparison was difficult. It was interesting to note that of those that knew ‘a few’ of their congregation the proportions in the three samples were similar, but it was surprising that more US patients knew no people in their congregations than the English service users.

To discover if the service users were able to disclose the fact that they had a mental health problem to people within the congregation I asked ‘Have you spoken to a friend in the congregation about your mental health problems?’ Over half of the regular church attendees had spoken to someone, but of those only six went to mainstream churches. Surprisingly one who said that he went to church ‘practically never’ and two who went ‘once a year’ had spoken to someone in the congregation about their mental health. Therefore, 18% of the total sample of patients had talked to someone in a religious congregation about their mental health problems. Unfortunately nearly half of these found this unhelpful.

Although over a quarter of the sample currently attends a place of worship, forty-six had attended at some time in their lives. Five attended within the last year, eight ‘within the last five years’ and thirty-one ‘over five years ago’. Many reasons were given why they no longer attended a church:

1. **changes of life** – growing up, finishing school, leaving home, “finished National Service”, “moved country”, “went with aunt”
2. **changes in belief** – “stopped believing”, “changed belief”, “no longer feel fulfilled”
3. **not liking the services** – “too evangelistic”, “too early”, “service too lively”, “too many”, “too many patients”
4. **escaping from cult**
5. **custom** – “I only went to Sunday School”, “just went to get confirmed”
6. **other pursuits** – “found better things to do”, “did other things on Sundays”
7. **mental illness** – “felt ostracized because of my mental illness”, “panic attacks”, “people judgmental about my illness”, “illness not understood”, “hospitalised”
8. **other** – “lost urge to attend when turned down for ordination”, “mother almost died and I blamed God”, “did not want to go alone”

Most of the reasons given for stopping attending a place of worship would be applicable to the general population. However, those under the category of ‘**mental illness**’ were applicable only to the service users, and although they were deeply felt by the particular
person they were mentioned by only five people. There did not appear to be a culture of stigmatization within the church, simply the respondents were part of a secularized society.

The more existential question taken from the European Value Survey 1990 ‘do you think about the meaning and purpose of life?’ was asked and a comparison made with the general population: the service users were slightly more likely to think about it than the general population.

Table 5.31: Meaning and purpose of life, compared to general population of Great Britain/percentages

<table>
<thead>
<tr>
<th></th>
<th>Service Users</th>
<th>EVS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=100</td>
<td>N=1484</td>
</tr>
<tr>
<td>often</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>sometimes</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td>rarely</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>never</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: EVS 1990

When asked if they thought about ‘death’, 40% thought about it ‘often’, which was twice the proportion of the British population (European Value Survey 1990). It was one of the questions that upset some of the service users when it brought back memories of friends who had committed suicide, and reminded them that they too had contemplated suicide.

However, 53% of my sample found that they received ‘strength and comfort from their religion’. Fitchett et al found that 68% of his US psychiatric patients and 72% of the US physically ill patients said that religion and spirituality was a source of comfort and strength. They concluded that:

...although there are some differences between the two groups, both hospitalised psychiatric and medical/surgical patients identify spirituality and religion as an important factor in their overall well-being. (Fitchett, et al. 1997:324)

Fitchett found that his two samples reported equal religious needs: 58% of the psychiatric patients and 50% of the physically ill, however the psychiatric patients described receiving fewer religious resources. Using the same questions as Fitchett I examined the religious needs and religious resources of my service users.
### Table 5.32: Religious Needs – comparison of English and Us patients/percentages

<table>
<thead>
<tr>
<th>Religious belief needs:</th>
<th>English Service Users N=100</th>
<th>US Psychiatric In-patients N=51</th>
<th>US Medical/Surgical N=50</th>
</tr>
</thead>
<tbody>
<tr>
<td>To know God’s presence with me.</td>
<td>54</td>
<td>84</td>
<td>82</td>
</tr>
<tr>
<td>To have a purpose and meaning in life.</td>
<td>90</td>
<td>75</td>
<td>74</td>
</tr>
<tr>
<td>To be relieved from the fear of death.</td>
<td>58</td>
<td>51</td>
<td>46</td>
</tr>
</tbody>
</table>

**Religious practice needs:**

| To be able to pray. | 62 | 80 | 88 |
| To have the sacraments and communion. | 30 | 39 | 46 |

**Religious supports needs:**

| To have the care and support from another person. | 89 | 90 | 94 |
| To have a clergyman or woman visit and pray with me. | 26 | 65 | 66 |

Source: Fitchett et al 1997

Over half of my service users felt ‘God’s presence with them’. Fitchett found that 84% of his patients compared to 54% of mine experienced ‘God’s presence’; the different levels of religiosity between the British and American samples may account for this. A high proportion of all samples needed ‘to have purpose and meaning to life’, but only about half had the religious need to ‘be relieved from the fear of death’. More Americans than English felt the ‘need to pray’ and to ‘take communion’. Only a third of my sample wanted to have ‘the sacraments and communion’ which was more than the quarter who said that they attended a religious service but less than the 59% who described themselves as ‘religious’. It was possible that some patients were unsure what was meant by ‘sacraments and communion’ and may have wanted to give a positive impression, in the same way that patients will identify themselves as ‘Church of England’ when in reality they never go to church. Having the ‘care and support from another person’ was ranked as the most important religious need by around nine-tenths of all the respondents.

It is noteworthy that the comparison between the three samples brought out the difference in the religiosity of the two cultures rather than between the mentally ill and the general population. The American samples rated ‘knowing the presence of God’ and ‘praying’ as key religious needs and wanted ‘to have visits from the clergy’, while the English service users needed ‘to have a purpose in life’ and three-quarters did not want to see any clergy. In fact nearly half the service users had spoken to the clergy about their mental health problems, 37% of the men and 57% of the women. Twice as many men as women spoke to clergy while in hospital, whereas twice as many women as men...
talked to clergy in the community and church. This may be because the hospital chaplain goes around the hospital wards and gives all the patients the opportunity to talk with him, whereas in the community the patient has to seek out the clergy. Women were also twice as likely to discuss their mental health problems with clergy in several locations: hospital, community and church. It appeared that men mostly discussed their problems with clergy during a crisis of being hospitalised, while women were happier to talk about their problems when they are not so ill.

5.4.9 Summary

In most aspects of religious beliefs and practice my sample of people with enduring mental health problems was similar to the general population. Hay's propositions that religious experiences were most often reported by older, well educated, women, middle class and from small town areas was born out in my sample: the older, well educated women reported most religious experiences, although class was more difficult to assess because all the different working groups were equally likely to have had one. However, as has been noted class was a difficult construct when looking at mentally ill people who may have suffered 'downward drift'.

My sample was also comparable to the general population in that older women were more likely to be 'religious', pray more, 'attend church' and on a 'more regular basis' than men and younger people. They were also similar in their beliefs in astrology.

Where they differed was that more service users looked to religion for comfort, God was more important in their lives, and all ages and both sexes were more likely than the general population to believe in God or 'a life force'.

The most significant difference was in their beliefs about 'life after death'. They were slightly more likely to think about 'the meaning and purpose in life' but twice as likely to think about 'death'. A higher proportion of the service users believed in 'life after death', a 'soul' and 'heaven', but twice as many as the general population believed in 'hell' and 'the Devil'. These issues would be examined in the second interviews.

5.5 Discussion of Spiritual Issues with Professions

Much has been written about the 'religiosity gap' between mental health professionals and the mentally ill. I wanted to know if my respondents were hindered in discussing religious issues with medical staff. This was discussed in depth with some of the service users in the recorded interviews and will be analyzed further in Chapter 7.
I asked my respondents if they would be happy to talk with a doctor or some other medical person about any religious ideas or religious experience, and if they had actually done so. Less than half of the men (46%) and women (43%) were happy to talk about religious matters, and when asked if they had in fact spoken to a professional about religious issues only 32% of the men and 27% of the women had done so.

I looked to see if there was a difference depending on how the service users described their religiosity: of the fifty-nine service users who described themselves as ‘religious’ half were happy to talk about religious matters with a professional. What was interesting was that ten respondents who described themselves as ‘not religious’ were happy to talk about religious matters to a doctor, as were three ‘convinced atheists’. Although nearly half (45) of the religious service users were happy to talk to a doctor about religious concerns only thirty had in fact done so. Four of the service users who described themselves as ‘not religious’ had spoken to doctors, two of the ‘atheists’, and two ‘don’t know’.

It appeared therefore that service users in my sample were not inhibited in speaking to a mental health professional about their religious concerns. However, most of those who made a comment said that they preferred to keep their mental health and religious issues separate, but if they wanted to talk about religious matters they would do so. It seemed that it was the service users’ preference and decision whether they talked about religion rather than any influence from the staff.

Twenty-nine respondents had spoken to at least one medical professional about religious matters, and many had spoken to several. Twenty-five of the respondents had talked to the consultant, nine had talked to the senior registrar who changed approximately every two years, nine had spoken to a registrar who changed every six months, eight to an occupation therapist, nine to a community psychiatric nurse, and one to an ‘other’ member of staff. Most had spoken within the last six months.

I wanted to know how they had found the experience of discussing their religious experiences with the professionals, so enquired if they felt that their beliefs had been ‘understood’, ‘respected’ and ‘shared’. The last aspect of ‘sharing’ the experience was to try and assess if the service user felt that the staff member had the same religious understandings or belief systems, as some mentioned that they thought some of the staff were Christians. I also hoped to draw out whether they felt that their religious views were regarded seriously or interpreted as delusional by some staff members. Some of those with more bizarre belief systems laughed and said ‘no’. One respondent felt that
eating magic mushrooms was the way to get enlightenment and understood that the staff did not share his belief.

53% of the men and 80% of the women felt that they were understood. 58% of the men but all the women felt their views were respected. 32% of the men and 40% of the women felt that their views were shared. It appears that more women than men felt understood, respected and shared.

Finally I asked the service users if they had found talking to a medical professional ‘helpful’, ‘unhelpful’, ‘confusing’ or ‘other’. Eight men and five women found it helpful, seven men and two women unhelpful, one woman confusing, and four men and two women ‘other’. Women found it more helpful than men did.

5.6 Conclusions
Returning to my research question posited in Chapter 3:

1. ‘How similar or dissimilar were my sample of service users to the normal population’?

It has been shown that they were very similar to the general British population analysed in the World Value Survey 1990 in most measurements of religious beliefs and practices except their greater beliefs about hell and the Devil and thinking about death more often.

2. ‘Was there a gender difference in the respondents’ views’?

There was a considerable difference between the genders. Women were shown to be more religious than men in both belief and practice, as in the general population.

3. ‘How did the sample compare with other groups of psychiatric patients?’

It was only possible to compare them in detail to one American sample that was shown to follow their cultural norm and be more religious than my sample. They were similar to the English service users in the Mental Health Foundation Survey in that over 50% were interested in spiritual matters, but the study did not break down the finding further.

4. ‘What part did religion play in the service users’ lives?’

Over half described themselves as religious but only one quarter attended a place of worship regularly. Half received comfort and strength from religion. God was important to 50% of the patients and unimportant to 35%, with 15% indifferent. More people believed in a ‘life force or spirit’ than ‘a personal God’. In line with the general
population the service users were superstitious, reading horoscopes and over half owning 'holy objects' and one fifth 'lucky charms'.

5. 'How many respondents reported having had a 'religious experience'?'

67% had an occurrence of what they understood to be a 'religious experience'. This compares to 46% of an American population of psychiatric patients.

6. 'How did the dual labels of 'mental illness' and 'religious' impinge on the patients' lives?'

Being mentally ill did affect the service users in all areas of their lives: work, friendships, accommodation and involvement in organisations such as churches. However, they did not identify any evidence of having been labelled as 'religious', and therefore they did not perceive that people regarded them as different because of their belief systems. If they held religious views these were not interpreted as a sign of mental illness, i.e. 'religious mania', but were regarded simply as a life choice as with any other member of society. They did feel labelled as 'mentally ill', but not 'religious'.

7. 'How free were the service users to talk about their mental health problems and religious ideation?'

On the whole service users did not seem to be hindered by professionals if they wished to talk about mental health or religious issues. Many did not choose to discuss issues that they considered to be personal matters. Many stated that they chose to keep their religious beliefs separate from their mental health problems.

The main finding from the overview of the religiosity of my sample of people with enduring mental health problems was how similar they were to the general population in their religious beliefs and practice. With a few exceptions, they did not suffer from 'religious mania' or 'delusional religious ideas' any more than might be found in any religious organisation, particularly a fundamentalist church or religious sect.

Where they did differ from the general population was in the more frightening side of religion: twice as many service users thought about 'death', and believed in 'hell' and 'the Devil'. Many looked to a better life to come, and more believed in 'life after death', a 'soul' and 'heaven'. God was more important in their lives than in the general population and more looked to God for comfort.

Clearly my mentally ill sample did look to religion for answers and help with their lives.
In the in-depth interviews the reasons for this will be explored.

Nancy Ammerman (1994) said in her Paul Douglas Lecture “This is a time in the history of our discipline (Sociology of Religion) when we need to hear many voices, listening to the varied stories that describe our world today”. She went on to describe how she suddenly realised that “stories belong to those who have the power to speak them”,... “those whose lives count in ways that other lives do not”. She commented that feminist writers “remind us that the first step in reconstructing what we think we know about the world is listening to the voices - the stories – of those on the margins”.

The voices that count in the world of the mentally ill belong to the professionals. In this research I wanted to listen to the voices on the margins – the service users’.

In Stage 2 of the research thirty-six service users were interviewed in depth to talk not only about their religious experiences, but also of their experience of religion as a sufferer with mental health problems.
Chapter 6

Religious Experience

6.1 Introduction

When investigating religious experiences Hay (1982) found that many of the people who related their experiences to him commented that it was the first time they had told anyone about them. Others confessed that they were wary about the response they would receive mainly because they feared they would be "classed as mentally unbalanced" (1982:158). He felt that people's reaction was similar to asking them to discuss intimate sexual experiences in public. "There is the same feeling of tentativeness, followed by rapid retreat if no response or an insensitive one is detected" (Hay 1982:159). This was very true of my sample: there was a recognition that I was asking very intimate, almost untouchable, questions that were intrusive, and that my response to their answers needed to be empathetic and reassuring.

Apart from one service-user who was banned from discussing any religious matters in the workshop because his constant proselytizing disturbed the other workers, my sample seldom talked about any part of their religious lives let alone their religious experiences. The fear of being considered deviant from the norm made them cautious about expressing any religious views. As Glock and Stark wrote "Characters in contemporary literature rarely undergo such encounters with the divine; and when they do, it is usually clear that they are odd people, old fashioned, simple, demented and the like" (quoted in: Hay 1982:115). My respondents were already labelled as 'mentally unbalanced' because they were being treated for a mental illness, and they had first hand knowledge that many of their experiences were dismissed as part of that illness, whether the content was religious or not. As one on my respondents Lottie said, when asked if she had ever spoken to a doctor or medical person about her religious experiences, views or needs, "they would think you weren't all there. They take things as very black and white. If you go on about it they could put you on a section. Someone not with mental illness, if they said things like that they wouldn't be put on a section" (IS)4.

4 IS indicates that the information is taken from the interview schedule completed in the initial interview.
This chapter will analyse the religious experiences that sixty-three of my respondents related to me – four people were unwilling to describe their experiences. They were written down verbatim on the interview schedule during the initial interview, when I asked one hundred users of one Psychiatric Service “Have you ever had an experience that you might call spiritual or religious?

6.2 Overview of My Sample’s Religious Experiences

There is a noticeable difference in the fluency of thought and expressive language between the narratives of my mentally ill cohort and those quoted by Hardy (1979), which were taken from the first three thousand experiences that were sent to him after he had advertised in the British press. Likewise the quotes from Hay’s (1979) sample of post-graduate students show no sign of the disjointed or very brief accounts that characterise my respondents’ reports. This could be due to fact that the accounts from the other two samples were written by the respondents, thus giving the authors time to process their thoughts and memories, whereas my respondents were required to describe their experience while I wrote it on the interview schedule. However, thirty-six of my interviewees agreed to engage in a second recorded interview when they did have longer to recollect their lives, and could express their experience at length if they wanted to. Although many took the opportunity to explore how they ‘experienced religion’ in their lives, few went into great detail of their ‘religious experience’. Lack of processing time did not, I feel, account for the meagreness of the description of their religious experience.

I believe that a more probable explanation for the disjointed nature, the brevity of their accounts and the inclusion of seemingly unconnected information was the fact that they all suffered from enduring mental illness and were taking medication. The former, mental illness, causes a disruption in mental processing making the effort of first recollecting the past, and then expressing it in words, laborious. The latter, medication, can cause a variety of troublesome side effects: dry mouth – creating difficulty with articulation; slurred speech (which is evident on the recordings) – can affect enunciation, consequently sentences and words have to be repeated to make comprehension possible; lethargy – taking away the desire to communicate at all; ‘tardive dyskinesia’ in which there are involuntary movements of the face, tongue or body – producing physical difficulty with speaking; and flattening of emotions – so that recapturing and recounting what might have been a momentous experience for the individual is dulled and the intensity of the occasion is lost.
Sixty-seven of my sample of one hundred service-users did acknowledge that they had had a religious experience, and all but four of them were willing to give me an account of it. Although they were receiving treatment for long-term mental illnesses they were a group of people indistinguishable in most ways from the general population and I wanted them to know that their experiences were valued. Therefore, their accounts were privileged and in no way rejected as being different from any other person’s religious experience, however terse the descriptions or how wide of the cultural norm they might be.

The very laconic nature of the descriptions made it imperative that no data should be lost or trivialised. To facilitate analysis, all the experiences dictated by the respondents during the initial interview that were written on the initial interview schedule have been quoted in full in the Appendix 6, together with some salient biographical information about each respondent.

Each experience has been coded to denote the classification and subsidiary divisions as shown in Table 6.1.

Example: I felt the presence of God in a small way. He helped me through a bad time. Lewis (IS) 1(i)

"I felt the presence of God in a small way.” Experience from the interview schedule.

Lewis [respondent’s name] 1 Presence of the supernatural (i) God (See Appendix 6)

Thirty-six respondents participated in a second in-depth interview which was recorded. Within this chapter, the experiences taken from the initial interviews which were written on the interview schedule are printed in italics, whereas additional information and religious experiences recorded in the second in-depth interviews are written in normal text and coded (RI): Recorded Interview. Comments made during the initial interviews were written on the interview schedule, and where quoted in this chapter are coded (IS): Interview Schedule.

6.3 Analysing the Religious Experiences

It was necessary to produce a coding frame for classifying the types of experiences as frameworks used by other investigators of religious experiences (Argyle 2000; Hardy 1979; Hay 1979; Pupynin and Brodbeck 2001), would not adequately accommodate those of my respondents. Unfortunately this made it difficult to make comparisons with other samples.
The classification generated by induction consisted of six main categories, which were subdivided into subsidiary divisions to identify the ways in which a particular aspect of the experience was reported. Inevitably there was some blurring and overlap of the categories, and sometimes it was difficult to distil the narrative to extract the central core of the experience. However, all but one of the experiences could be assigned to a single heading: one experience contained two categories, and one respondent recounted two separate religious experiences.

The six main categories took account of:

1. The respondents' encounter with the 'Presence of the Supernatural', both 'God' (nine respondents) and 'Other Supernatural forces' (six respondents). Although most of the respondents had been socialised within a Judeo/Christian culture with a monotheistic God, one respondent practised devil worship and one woman was a fervent Hindu worshipping multiple gods.

2. 'Prayer' was the main category for seven respondents, although it was mentioned in many other accounts. It is central to most religions, be it in the form of liturgy within institutional religion, personal prayer or meditation. It was personal prayer that was spoken of by my respondents.

3. 'Christian experiences' were divided into 'Conversion', 'Baptism of the Holy Spirit' and 'Baptism'. Whereas the first two are experiences mostly associated with Protestant Non-Conformist forms of Christianity and Charismatic churches of all denominations, the third is a central tenet in all forms of the Christian religion.

4. Twenty-eight accounts related to some form of 'Physical Sensations': respondents described being 'High'; or they experienced 'Hearing' sounds; sensing 'Heat'; 'Seeing' apparitions; having 'Feelings of peace, calm or nice'; but some experienced frightening 'Hallucinations'.

5. Five subdivisions were placed under the heading 'Extraordinary Experiences': 'Out of Body'; 'Near Death'; 'Healing'; 'Warning'; 'Déjà Vu/Premonition'. All except 'Healing' were psychic and could be considered to be occult in nature, but the respondents considered them to be religious. While all religious experiences are 'extraordinary' i.e. occurrences out of the ordinary in everyday life, these five would be considered outside the norm of most religious
practitioners. Although 'healing' would be normative in many Pentecostal or Charismatic Christian denominations it is out of mainstream Christian practice and therefore placed in this section.

6. The last category was 'Reflexive' as the experiences were introspective, or relating to the effect the experience had upon the respondent.

Four respondents would not relate their experience, but I had no reason to doubt that they had experienced one as they expressed other religious features: three stated that they were 'religious', and the fourth attended church weekly although he stated that he was 'not religious' because as a committed Christian he objected to the term.

The first three categories – 'Presence of the Supernatural', 'Power of Prayer' and 'Christian Experiences' are conceptualised as experiences relating to 'Conventional Religious Practices'. They refer either to encounters with supernatural beings, which most people would consider to be religious, or to elements of religious process such as prayer or Christian rituals.

The next two main categories 'Physical Sensations' and 'Extraordinary Experiences' are conceptualised as 'Experiential'. Although the experiences were labelled as 'religious' by the respondents they did not belong to any particular system of beliefs. They were occurrences which were physiological in nature to which the respondents gave a religious interpretation.

The last classification 'Reflexive' experiences are sui generis: they are neither physiological sensations nor relate to external phenomena, but they reflect either the way the respondents view themselves or how the experience has affected their lives.
Table 6.1 Classification of Religious Experiences

<table>
<thead>
<tr>
<th>Main Classifications</th>
<th>Subsidiary Divisions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Presence of the supernatural:</td>
<td>(i) God</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>(ii) Other Supernatural</td>
<td>6</td>
</tr>
<tr>
<td>2. Power of Prayer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Christian experience:</td>
<td>(i) Conversion</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(ii) Baptism of the Holy Spirit</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(iii) Baptism</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Conventional Religious Experiences:</strong></td>
<td></td>
<td><strong>29</strong></td>
</tr>
<tr>
<td>4. Physical Sensations:</td>
<td>(i) ‘High’</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(ii) Smell</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(iii) Hear</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(iv) Heat</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(v) See</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(vi) Feelings of: peace; calm; “nice”</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(vii) Hallucination</td>
<td>3</td>
</tr>
<tr>
<td>5. Extraordinary Experiences</td>
<td>(i) Out of Body</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(ii) Near Death</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(iii) Healing</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(iv) Warning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(v) Déjà Vu/ Premonition</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Experiential Experiences:</strong></td>
<td></td>
<td><strong>31</strong></td>
</tr>
<tr>
<td>6. Reflexive Experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Reflexive Experiences:</strong></td>
<td></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td>7. Would not relate experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 67 Respondents</td>
<td>Total experiences</td>
<td><strong>69</strong></td>
</tr>
</tbody>
</table>

6.3.1 ‘Presence of the Supernatural’ (i) God
The largest number of experiences came under this heading, which was to be expected when enquiring about the religious experiences of a group of people socialised within a predominantly Christian culture. Most religious experiences would tend to be interpreted within a Christian framework with a monotheistic God as central to the religion.

However, the nine respondents whose experiences came under this heading focused on different aspects of their relationship to God. Three spoke of feeling His presence:

*I felt the presence of God in a small way. (IS) Lewis 1(i)*
I have felt His presence. (IS) Ben 1(i)

Ben not only said that he felt God’s presence with him but also that “I get help from God” 1(i)(IS) This gentleman was not brought up religiously at home and had never attended any religious services but he considered himself to be ‘religious’. Clearly God was a beneficial element in his life but this did not lead to any involvement with institutional religion.

Val also felt that God had helped her.

I do think that God has helped me in some ways you know. I just think He has helped me. Encouraged me to go to church. Just little things really like take part in the bring and buy sales and take part behind the stalls. Be in the choir. Things like that. (IS) Val 1(i)

Val had been very uneasy during the first interview while filling in the interview schedule, and said at the time that she did not want to describe her experience nor participate in a second interview. However, her name was mentioned by several other respondents during recorded interviews as having been instrumental in encouraging their religious life when in the old mental hospital, so I was keen to speak to her further. The gatekeeper in her place of sheltered work, and the other respondents who told her that they had enjoyed their recorded interview, encouraged her to speak to me. It transpired that she was very nervous of ‘paper and pencil exercises’ as they made her “feel stupid”, and that accounted for her anxiety during the initial interview. After assuring her that only a tape recorder would be used she was happy to speak to me and put her experience into words. Unlike the first interview she was not apprehensive and said that she benefited from speaking about her religious life. Her experience was not mystical, but related to a supernatural being who was a living reality in her everyday life who helped and guided her.

Joe’s case was noteworthy: in the first interview he said that he had had an experience but would not describe it, merely stating, “The experience is personal” (IS). In fact when asked during the initial interview ‘if he had ever felt in the presence of God’ he had replied ‘other’, because he considered the response to be “personal” information. However, by the time I started the second in-depth interviews he was more stable mentally and was happy to talk to me. I noticed that my field notes read; “it was a very pleasant surprise and relief that Joe’s demeanour had changed, as he had been very anxious and irritable throughout the first interview, and said at the end “this is doing my head in””. Fortunately he had forgotten his initial reticence and put into words his
relationship with God:

In the past I have been on my own but I haven't felt alone you know. It is as if someone is there but I can't see him. The only explanation I have got for it is it has got to be God like. (IS) Joe 1(i)

This case portrayed the difficulty of researching such a vulnerable and unstable sample. Although this respondent knew me well, if I had not been interviewing other respondents in his sheltered work area on this occasion and sat and worked alongside him, he would never have agreed to a second interview and I would not have discerned the way he felt about God. Clearly his relationship with God was such an important aspect of his life that when he was mentally unwell and vulnerable he did not want to relate his feelings to a third party. I had never known that this young man was a practising Christian, and on his interview schedule he stated that God was neither important nor unimportant in his life (‘5’), and that he had only attended church ‘within the last five years’. In the second interview it transpired that he attended church on a regular basis and often took his mother with him, although he had changed homes on several occasions which altered his attendance pattern.

One respondent had a very powerful experience twenty-five years before the interview, when he felt that Jesus had been a physical presence to him.

I was very religious when I was younger and had a feeling of Jesus within me. When I was fifteen I was camping in a Bell tent. I felt someone saying ‘go on, get up and tell them I’m here’. I felt pushed on to an arena – I felt the push on the shoulder to speak. I got up. I felt Him around me during that fortnight. (IS) Tom 1(i)

Although he no longer went to church he defined himself as ‘religious’ and felt that God was important in his life (On the Importance of God Scale ‘1’-'10’ he rated himself ‘8’).

Another respondent reported that God had become real to him because of an experience he had when mentally ill, although he had not had a religious upbringing. He said that he did not attend a religious group, but had briefly attended The Church of Jesus Christ until earlier that year when he left “because I got too involved with evangelism” (IS). He still considered himself to be ‘religious’ and ‘got comfort from religion’, but did not like the religious coercion within the church he attended.

I didn't really believe in God until I was really quite ill. One needed some sign and I felt when I was in hospital I saw a bright star, you know. I found it almost like the star of Bethlehem in the sky. I saw that and I felt that gave me strength and since then I have believed in God
Richard l(i) said that God was a comforting presence for Hugh, but his experience could be characterised as ‘ineffable’: it was very meaningful and deep to him but he could not convey in words what he was seeing in his mind. His account was very disjointed with different images being intertwined with his physical experience of cataracts; however, he was neither confused nor suffering from florid symptoms of mental illness.

I have had multiple visions – mental images. When I was suffering I closed my eyes to sleep then suddenly my eyes opened a little bit. I had a vision in colour of mainly trees, and flowing leaves in the wind. I hear God saying ‘there, there, we are here’. It was like watching the telly. Not long, seconds. God was comforting me. I heard on the radio that visions are warnings but this was not a warning; it was God showing me that He was there. I had visions at the start of my cataracts – it gave me comfort when I was upset with the loss of my sight. I still get them. (IS) Hugh l(i)

Lucy was a devout Roman Catholic in her late forties, and at the time of the first interview she attended church weekly. She was an educated woman and qualified as a teacher at twenty-one years. Sadly her mental illness had terminated her ability to teach and she gave her last occupation as “cleaning” (IS). However, she was still a very articulate woman and poetically described what had been a very significant experience for her.

When I was picking thyme with my ex-husband [name], I was nominally looking for the Lord. When I put my hand on a leaf it was like Adam touching the finger of the Lord. There was a recognition of something sublime. God was in the World like a benign presence. It made me feel that there was something wonderful to reach out for. It was a time of great searching. It was like the Lord was saying ‘you are important to me’. I found out that thyme has a spiritual connotation. There is a play on the word time/thyme. Parallels in nature – timeless spiritual things. (IS) Lucy l(i)

In the second interview she referred to this as an “uplifting experience” (RI:23). It came at a time when she “first became aware of a benign God, you know, a God that really does love us…I was in the sort of in-between stage of beginning to think far more about spiritual things and I think this is where God often touches us when we are at the beginning stages, and we need these encouragements” (RI:23). Lucy wove a rich pattern...
of connections: not just in the visible world around her but in the imagery of her thoughts and feelings. However she related another experience which she had when feeling “oppressed and persecuted” (RI:27), which demonstrated another view of God which was not a “benign” being that loved her as a human would, but a presence like light which enveloped her. She described it as a reverie she experienced while reading the Bible: “you avert your gaze from the pages and you begin to have experiences” (RI:27).

I had an experience, an incredibly powerful experience, this was a very very powerful experience of God...I was in a state of being taken up to Heaven,...I was being taken up by the angels...that was only the beginning. The interesting part was what happened next...I heard a voice crying out to me "Help, help, help me, help me" and the good angel said to me "Whatever you do don't look back, we're taking you up to Heaven and you mustn't look back". ...I'd not been reading anything that would indicate you know suggest ... the importance of not looking back, that type of idea. It's a bit Greek myth when you think about it? Orpheus. And anyway,...the plaintiveness, the cry to the heart of this person's voice, I could not,...I had to turn back and funnily enough it was a person I had known years ago, she was a teacher at a school I had been teaching at and I used to have tremendous arguments with her. I have to point this out because otherwise the context of this whole thing is just a bit meaningless for me if I don't tell you. She was ...I suppose in short what we would call a terrible, a real racist. It was this person who was crying, crying out. ...And anyway the moment I turned back to help, because it was a cry of the heart, it was anguish, such an anguished cry, I had to turn back because she was saying "help, help", and I stretched out to reach her you know, and the moment, this is where the sort of time scale was so um unlike our own, the minute I was - this is the curious bit, the minute I stretched out and reached out for her I started to turn into a reptile, I became a rep, I er, became, my skin became all scaly. I looked down and I was beginning to become a reptile and at that moment there was a tremendous, I mean the extraordinary thing was I was aware of a tremendous battle. It wasn't so much, it was more, it wasn't just a visual sense of battle it was an almost total sensory thing. The sounds of battle, the sounds of metal, the bad angels were metal, they were making you know, the clash of steel, and the sound of feather you know personified or sort of symbolising or representing the good, and the metal representing, these angels were made out of metal. These evil angels were made out of metal - it was very strange, and the sound of clashing of swords perhaps the good angels, I don't know but they were all sort of fluffy. No, not fluffy, but they were, they were feathery, they were making flight noises... I was just aware of a tremendous battle, it was awful, it was extraordinarily on my behalf. That's what I was aware of that this tremendous battle was being fought for me, little me. I couldn't believe this.... I mean the incredible thing was I knew that I was terribly injured. I mean I was terribly, terribly injured, because I wasn't reptile. I was being pulled away and the good angels in their fight to get out of this, I had been injured by it obviously, but the curious thing was
that they seemed to be able to drag me up to Heaven and I died. I don't know whether I died or my soul or my, I just don't know what part of me died. But I died in the embrace of God. And God wasn't a human being, it wasn't a sort of visual thing it was like a sort of what? A substance or almost a sort of I don't know what would you call it 'an element' – 'light', the element was light, it was the embrace of light. So it was an extraordinarily powerful thing, reverie or, it was an experience that I'll never forget. I do remember it in all those details. You know it had this sort of um incredible impact on my life. Lucy (RI:27-40)

The experience had many Biblical features: the battle between good and evil; heavenly and satanic angels fighting for the souls of the saved; heaven and hell. She was able to portray the fighting that was raging within her while feeling persecuted, and her need of someone to fight for her: she needed to process and express the agony of her mind and spirit and this took a religious form.

Of the nine respondents who reported a religious experience relating to 'God', only three were female. Two were aged between 26-34 years, five 35-44 years, and two 45-65 years: all were old enough to have had Christianity taught to them at school. They all identified themselves as 'religious' and four gave the Importance of God in their lives the highest score of '10'. Of the nine respondents only four attended a religious establishment, and those four attended weekly: three frequented churches in the community, whereas one felt more comfortable at the church which had been established for people with mental health problems and learning difficulties.

6.3.1 ‘Presence of the Supernatural’ (ii) Other Supernatural

The second subsection of the ‘Presence of the Supernatural’ referred to ‘Other Supernatural’ beings. Understandably these six respondents identified themselves as slightly less religious than the first category: one was a ‘Convinced Atheist’ and one was ‘Not Religious’ - both of them gave the lowest score for the Importance of God in their lives ‘1’. Only one respondent in this group attended a religious service – this was weekly at the local Church of England.

Edmund was the ‘Convinced Atheist’ and said “I practice devil worship” 1(ii). When asked if he got ‘comfort and strength from religion’ replied “Yes, from devil worship” (IS). In response to the question ‘How often, if at all, do you think about the meaning and purpose of life’ he replied “Never – it’s a waste of time”. He said that he believed in ‘A soul’, ‘The devil’ and ‘Sin’ and had a lucky charm – “star of devil worship” which
he thought ‘protected him’. This was a ring which he showed me proudly. He related his experience:

*It felt like there was another power in the room which came on to me. It felt good like I had more strength than I really had.* (IS) **Edmund** 1(ii)

I wrote in my field notes that “I did not ask him for a second interview because he was a very elusive person – I only managed to see him because he came in to have his arm treated by the nurse. I did not feel that he really regarded his experience as religious”. I found him menacing and believed that in an unstructured interview I would be out of my depth discussing his occult practices with him. I was aware that I might put myself in danger, because never having worked with him I would not recognise any warning signs and might trigger symptoms of his mental illness.

Less dramatic was **Jacob**, who although he said he was ‘not religious’ described an experience he had when “taking marijuana” 1(ii), which he interpreted as religious

*Oak trees. I had a vision of the mythical celestial oak. It influenced my creativity. I am a potter.* (IS) **Jacob** 1(ii)

**Grace** lost her fear of death through the religious experience she had when her brother died. She described herself as ‘religious’ and felt that her brother was still with her spiritually.

*Although I was very upset when my brother died, within twenty-four hours of his death I felt really OK and in touch with his spirit as it left his body. I felt it was a religious experience that he wasn’t suffering any more and that death wasn’t so bad.* (IS) **Grace** 1(ii)

One man aged 26-34 years, who described himself as religious and read the Bible, felt that he had been in the presence of God, although God was not very important in his life (‘4’). He said that he had attended the Church of England ten times in his life, once within the previous year, but was planning to speak to a Roman Catholic priest about his mental health problems. He related to me his religious experience, but I was unsure whether his experience was religious in nature or related to his mental illness because it appeared outside the cultural boundaries of the Christian religion which he embraced.

*I have seen spirits/ghosts. Ghosts talked to me from Heaven. When I was twenty-three/twenty-four I saw lights and the top half of my Granny. People were talking to me and I talked to people in Heaven. I was lying on my bed and sent embraces to Jesus in Heaven.* (IS) **Morgan** 1(ii)
I was keen to speak to him at length to understand more about his experience, and he agreed to a second recorded interview. Unfortunately he changed his mind and refused on two occasions, saying very politely each time “I would rather not”. However, on my third visit to the workshop that he attended, after dropping to the floor to do some press ups, he was happy to speak to me and afterwards said how helpful he had found it, and even encouraged others in the workshop to participate in my research. He explained, “I've been doing a lot of exercises, physical exercises and it has helped me really with my mental strife that I have been suffering... It clears your mind out really, and helps with the chest really...Press-ups, hit the bed, drill on the spot, um” (RI:298-302).

Although he appeared to be located within the mainstream churches, the second interview revealed that he and his mother were in fact Spiritualists. He explained that although his mother was not a medium they both were in touch with the spirit world. “We can just talk to the spirit world, both of us can.” He also explained why only the top half of his Granny was visible.

Well I didn't feel any presence, any emotional towards it really. There was no feeling, just saw the top half, her curly hair, very curly hair. She always liked the hairstyle curly hair, bushy hair, curly hair, and a frilly dress, the top of a frilly dress that she had on and a blouse.

*So what had happened to the bottom half of her?*

That wasn't there because sometimes they can't come all of it, because their power is limited. The protoplasmic power that they have in them, they can't completely um appear completely, all full figure because they only have limited power. And sometimes the power isn't strong enough to make them appear completely. It can strain their power, drain their power. They have to go to heaven to get their power back so they can put more ease in themselves.

*So where do you think your Granny is now?*

She is in Heaven now. On an astral plain. **Morgan** (RI:70-74)

I believed that his experience would have been familiar and acceptable within the Spiritualist Church. This demonstrated the importance of not dismissing religious experiences as symptomatic of mental illness, simply because the person revealing them is mentally ill and the experience appears outside the cultural norm.

The last respondent in this category was **Sharon**, a woman aged 45-65 years, who was a weekly attendee at her local Church of England. She was well integrated into the congregation, and was one of only ten people in the full sample of one hundred respondents who knew most of the people in the church. (Five of the other respondents
who knew the full congregation all attended the service-users' church, and it was
understandable that they should know the other members. Of the others, two attended
small minority sects and two a friendly charismatic church.) Sharon explained in the
second interview why she knew most of the people in the congregation: the clergy had
divided the congregation into two groups with different styled services, one modern and
one traditional. Sharon attended the latter. "We are a crowd but we are not so many
people, we're older and they tend to be older than me if you know what I mean. Yes
they are friendly, it is geared towards older people" (RI:113). She had always been
deeply religious and said that she had been a Christian "since they took me in a long
flowing robe when I was two months old into the church" (RI:79). Initially she did not
think that she had ever had a religious experience because she thought I was referring to
peak experiences: "I've never had a vision or anything" (IS). However, on the interview
schedule she described what she felt might be a religious experience.

*I have other-worldly feeling when the lights go down particularly in
the summer. (IS) Sharon 1(ii)*

During the second recorded interview she elaborated the account of her experience;
when asked if she felt that she had ever been in the presence of God she replied:

Well He is everywhere but no particular time. Well sometimes I do, when
the something, well I haven't had a religious experience but I feel God
when it gets dark, twilight and that. And especially in the summer I
suppose. I feel there is something. Nice something. It's nice. It's all to do
with nature I suppose.
*How long would that last for?*
Sunset makes me, when the sun is nearly set, on a summer evening and, it
really makes me feel close to something, God. Perhaps it is Pantheistic
you know, worship of nature. I don't know. It gives me a good feeling.
*And does that last into the evening?*
It makes me feel good but I don't know how long it lasts for. Sharon
(RI:141-145)

6.3.2 ‘Prayer’
As Hardy wrote (1979:137) "The element of spirituality which is at the heart of all
religion is the phenomenon of prayer. It is the channel of the ‘I-Thou relationship.’" The
prayer that was spoken of by seven of my respondents in their experiences was not
prayer that they related to organised religion: it was personal answers to their own
particular needs, and was seen as being brought about by the intervention of God. It had
about it the closeness of the “I-Thou relationship”, rather than being associated with
impersonal formalised repetitious phrases connected with childhood school assemblies
or religious services.

On the interview schedule two questions referred to prayer: ‘Do you ever pray, meditate or contemplate or something like that?’ (‘Yes’, ‘No’) and ‘How often do you pray to God outside of religious services? (‘Often’, ‘Sometimes’, ‘Hardly Ever’, ‘Only in times of crisis’, ‘Never’). In answer to the second question five respondents in this category said that they prayed ‘Often’ and the other two ‘Sometimes’. Of the total sample of one hundred interviewees 31% prayed ‘Often’ and 14% ‘Sometimes’.

Robert felt that his faith in God had been rewarded and his prayers answered: he saw God as instrumental in his discharge from hospital:

\[
\text{Having faith in God, praying to God and having my prayers answered. Getting out of hospital in 1988. (IS) Robert 2}
\]

It was interesting to note that Robert described himself as ‘religious’, ‘got comfort from his religion’ and said that ‘God was very important to Him’ (‘10’), despite not being brought up religiously at home and never attending any church services: in fact his parents had been very opposed to all religious practices.

Ann’s children were the most important people in her life and she saw prayer as a means of keeping them safe and in touch with her.

\[
\text{Answered prayer. I'll give you an example. I pray that I'll see [daughter's name] and not have to wait long. Well I don't see [daughter's name] but I pray that I'll talk to her. I panic a lot if she misses a phone call. And I find that somehow she always turns up. (IS) Ann 2}
\]

She said that she was religious and that God was very important in her life (‘10’). In the second interview she spoke more about her prayer life. “Well I don't do much without praying about it...Some of the prayers are purely about my family. Quite a lot of them are really. I find that I can't do much without help from God really” (RI:25-27). I asked her if she prayed in her mind or out loud, and where she prayed. She replied “Out loud. At home more than in church. I don't go to church very often” (RI:31). When asked whom she prayed to, she said, “I talk to Jesus, the Holy Mother, and God the Father” (RI:43).

Prayer for Ann was talking with friends about people for whom she cared deeply. By the time I interviewed her she was a very solitary woman, living alone and seldom going out. On the interview schedule questions were asked about belonging to clubs and
how they spent their free time. Ann did not belong to any clubs and spent her free time “thinking” (IS). In her solitude God became her ‘significant other’ and she talked to Him. In fact she said that she prayed to God not only for her children but also for her pets: “Um I pray for little Polly and Pauline my budgies that I’ve got. I pray for all the animals that I have had in the past, quite a lot. I pray that they will be all right and taken into heaven” (RI:77).

One articulate woman in her early sixties embedded her prayer life within her Christian identity:

_I was brought up a High Church Anglican...I have had answers to prayer on many occasions and learnt through being mentally ill the benefit of intercessory prayer. I have been led to people who really prayed._ (IS) Alice 2

She had been very religious since childhood and prayer had always been part of her life. She had suffered mental ill health for many years while working in a church setting, and throughout her second interview prayer was mentioned frequently: people were identified as “prayers” and “non-prayers” (RI:104), and she related how these different sets supported or judged her.

She felt that she had a very close relationship with God: “I mean God is a real presence to me, He is in everything that I do. He is in everything, He informs. I mean I don't exactly sit there thinking about Him but I do pray to Him and I do believe that His spirit is working within me when I give myself the time to pay attention to it. And it is sort of in everything. He is always there. I think about Him all the time” (RI:248). When deeply depressed she did not feel that God had deserted her, but was concerned that He might think that she had deserted Him because “I couldn't seem to communicate, and I couldn't fix my mind. It was during that hard period when my friends prayed and the ones that I felt did pray were sort of able to help me” (RI:364).

Both Luke and Olga saw healing as answered prayer:

_My mother got her eyesight back and I felt that this was an answer to prayer._ (IS) Luke 2

_I had my first son and my period stopped. I thought that a hand touched my head saying that everything will be OK. I felt a presence. My period come next day. My prayers were answered._ (IS) Olga 2

For Rose there was a tangible answer to prayer. She was an anxious woman who was
very scared of needles, so having to go into hospital for an operation was a terrifying ordeal. She was a devout Christian and attended the service-users’ church more than once a week. After the church group prayed for her she felt calmer.

*When going to have an operation I was very frightened. People prayed for me on the Tuesday before I had the operation on the Wednesday. I knew that God was there because I felt different. I felt calmer and I looked at the operation in a different light. On the day of the operation I was still frightened but not so frightened. (IS)* **Rose 2**

**Sam** aged 45-64 years described what he believed to have been a direct answer to prayer when he was in his early thirties in the 1980s.

*I was on the A3 in a car by myself. There was heavy rain. I wondered if I should stop but I continued at 30 mph. There was a huge thunderbolt. I prayed to the Lord to see me through the storm. I was going to Guildford and was very frightened. I was going up to a bridge and all of a sudden the skies brightened. I felt that this was a real answer to prayer. (IS) Sam 2*

He had been brought up religiously at home but now only attends church at Christmas and Easter. He felt that God was still very important in his life (‘10’) and said in the second interview that “He is always there to me. The Lord Jesus is always there. I have got this spiritual faith inside me” (RI:41).

Prayer was evidently most important in the lives of these respondents who had all at one time been practising Christians. All but two felt that God was very important in their lives, but only one still attended church regularly. They did not feel the need to participate in institutional religion to have a close relationship with God. Sadly it was the way the people in the churches had reacted to the respondents’ mental illness that had driven some away. This will be discussed further in the next chapter.

**6.3.3 ‘Christian Experiences’ (i) Conversion**

Four out of my one hundred informants recounted a conversion experience, which was the same proportion that Hay (1979) found in his sample of one hundred undergraduate students. Mental illness cannot therefore be seen as instrumental in their experience, particularly as the conversion occurred many years before the illness had become apparent.

Religious conversions relate to “a change towards more religious beliefs, behaviour and commitment” (Argyle 2000:19). They are most commonly associated with Non-
Conformist Protestant churches, but are also common in Charismatic churches of all denominations. Some occur suddenly, with a radical change in the person and may be compared to the Biblical story of St Paul on the Damascus Road, whereas others may occur over time as part of the socialising doctrine of the church. They are a prominent feature of revivalist, evangelical or charismatic meetings, and Argyle noted that 5.3% of those present at the large Billy Graham Crusades when invited to make a public commitment came forward. Most happen in adolescence and they are rare after the age of thirty years (Argyle 2000:20).

All four of my respondents fitted within this biographical framework of people who undergo a conversion experience: three belonged, or had belonged, to Non-Conformist churches and one to a Charismatic Roman Catholic church; and all of them had been under thirty at the time of conversion. Three described themselves as 'religious' and had attended church within the past year, but one said he was an ‘atheist’ although he still attended a Roman Catholic Church weekly with his parents.

Their experiences were very succinctly expressed on the interview schedule, and there appeared to be a given assumption that I would understand what they meant by an allusion to a “Billy Graham Crusade” (Laura), and such phrases as “born again” (William), “converted” (Maggie) and “gave my life to the Lord” (Sarah).

At a Billy Graham crusade those who want to know come forward and I did. (IS) Laura 3(i)

I was converted in Hyde Park by Cliff Richard when I was 18 years old. (IS) Maggie 3(i)

I became a Christian in 1989 and gave my life to the Lord. It was a very good experience. (IS) Sarah 3(i)

Basically I became a born again member, a Pentecostal Catholic version, at the age of 17. It was very intense while it lasted. (IS) William 3(i)

During the in-depth interviews I was able to investigate these experiences more fully, which evidently had been “good” for Sarah and “very intense” for William.

Laura had belonged to the Plymouth Brethren, and had been taken by her parents with the rest of “The Meeting” (IS) in a coach to a Billy Graham Crusade in the 1960’s. “...it was early Sixties so I was between ten and fifteen” (RI:104). She could not remember very much about the occasion except “going forward” (RI:110) with some other people
in her group. She could not recall her feelings, nor thought that it had any effect on her life at the time. She saw it rather as an initiation ceremony: “Um. I think I felt it was something you had to do. You know” (RI:118). However, having been brought up in a close family within a very strict Christian fellowship there was not the opportunity to convert from being irreligious to God fearing: she was already religious and her life was bounded by religious practices. “You went to Sunday School in the morning, something in the afternoon and something in the evening. Three times a day on a Sunday. It was something that you did naturally” (RI:94). I felt that she was correct: conversion was for her more an initiation ceremony when she accepted the group norms.

It was difficult to unravel Maggie's narrative. On the interview schedule she said that she had a religious upbringing and still attended a Free Church weekly, and that her religious experience was that she was “Converted in Hyde Park by Cliff Richard.” However, during the in-depth interview it was not easy to follow her train of thought and to know what was fact and what was her mental state: she related a story interspersed with extraneous details that were evidently meaningful reminiscences to her and may well have referred to real situations, but to me they were disconnected in time and place.

When I asked her to relate her conversion experience in Hyde Park she told me that when she was sixteen she had been in London for the weekend with her sister: “Well, I went to a party the night before with some people I knew...just some girls and blokes I met. ...and I heard Cliff Richard saying, “Listen to silence all over London”. Then I got interested, you know. You know, the Lord definitely led me to all these places” (RI:41-45). When I asked if they had gone to Hyde Park deliberately she replied, “No, we just came back from their place and were waiting for the Tube near Hyde Park and then we saw all these people. A load of German students and some people in T shirts. We were just on the edge and then we went in and found it...I didn't know the Lord before, I just was just standing there and watching people go in” (RI:47-49). When asked what happened after her experience in Hyde Park she replied, “Well, I felt the need to go to church after Cliff Richard spoke. I have been going to church ever since. And then soon after I was baptised” (RI:51).

It seemed strange to me that at the age of sixteen in the early 1960s Maggie and her sister should be in London for a weekend, attending a party with some people she did not know well, if indeed she came from a religious family.
Her response to my questions about the religious upbringing she claimed to have had portrays the difficulty I encountered understanding her life story.

*Were your family Christians?*
No.

*So you didn't have a religious upbringing?*
I was adopted.

*What age were you adopted?*
Six weeks old.

*Were both you and your sister adopted into the same family?*
Mm (yes). My mother was Church of England. Mr [name] prayed and she went to church and hadn't been for thirty years. I prayed for my Mum because she got cancer. She died about 19 years ago. My Dad retired. I had problems when I first went to the Church our minister said 'don't preach, sow the seed and leave it'. Anyway he went completely haywire and kept going on about money. He was always quite difficult. My mum was a lot older than him. About 29 years older. He's married again now though. Maggie (RI:70-77)

Having never worked with this woman I did not know her background history. I sifted the details of her narrative as she had related it to me, and understood that when in her teens Maggie had experienced an event in Hyde Park that was very meaningful to her which had an ongoing effect on her life. She interpreted this experience as a religious conversion.

Another account that was very briefly described on the interview schedule was Sarah's experience: “I became a Christian in 1989 and gave my life to the Lord. It was a very good experience.” At the time she was very keen to talk to me further to try and work through her experience of religion and how it had affected her life. However, she found expressing herself demanding and it was difficult drawing out her narrative. Although she knew me well and always liked to talk, she was timid and softly spoken with everyone and her thick Scottish accent was sometimes challenging to understand.

She had been brought up in Scotland in the Church of Scotland, but had rebelled as a teenager and had left home. She related how she was converted.

... and then when I left home in 1999 I gave my heart to the Lord.

*What happened?*
Well these two guys [name], and I can't remember the other man's name, but they came round preaching around the streets. And that's how I got involved.

*When you say you were on the streets is that when you were homeless?*
Eh no, I was in the board and lodgings and me and my pal used to go out on the street and have a few bevvies, stand around the streets and they used to come round evangelising.
What was your reaction?
Actually I can't remember.
So what happened?
Em I just thought I would go for a laugh.
Did you go to a meeting or something like that?
Yeh I went to one of their services.
Was that in a church?
Pentecostal church. (She opened her eyes wide expressing amazement)
Had you ever seen anything like that before?
No I hadn't. No. I loved it. Yep.
How was it different?
Well mostly in the Church of Scotland people are just sitting there
listening to the Minister. But in the other one it is more joyful.
Worshipping, and people are up there singing and dancing and singing for
joy.
Did you realise anything like that existed in religion?
No. no.
So then what happened?
Eh. I then got baptised. Em. I sort of had a fall out with one of the
ministers and never went back. Sarah (RI:33-53)

Later she talked more about her spiritual experiences within the church.

When you said you gave your heart to the Lord what exactly happened -
did you have an experience at that time?
Yeh I felt the Holy Spirit and I've still got the gift of tongues.
When you felt the Holy Spirit what did you feel?
Quite a good, nice, good sensation (she wriggled excitedly in her chair).
Right the way through you?
En her (yes). En her (yes).
Did you fall?
Yeh.
And how long were you down?
Not that long. Not that long.
And did you speak in tongues straight away?
Yeh.
Do you still use the gift now?
I know I've still got the gift.
So how long did you go to the church for?
About two or three year, I would say...I know I still got the faith, and I
know God will never leave me. I know that.
And does that help?

Her faith still meant a great deal to Sarah and she said that it helped her with her
depression, especially when listening to her Christian music tapes. She said that she
would go to a Pentecostal Church again if she had someone to go with. Several
respondents felt that they would like to go back to a church but would not want to go on
their own.
For William religion had turned from being a beneficial source of intense pleasurable experiences and companionship with other believers, to disillusionment, self-reproach and loneliness.

He described his religious experience:

*Basically I became a born again member, a Pentecostal Catholic version, at the age of seventeen. I was speaking in tongues and it was a very intensive social meeting of people. I got a lot of good friends from that. Coming to England from Rhodesia on my own knocked it out of me. I don't belong to that scene any more, but it was very intense while it lasted.* (IS) William 3(i)

He was highly intelligent and had been a talented musician, and pointedly described himself on the interview schedule as 'A convinced atheist', despite attending a Roman Catholic Church weekly with his father and giving the highest reading on the Importance of God scale '10'. The reason for this dichotomy became apparent during the second interview when he described the painful disenchantment with Christianity that followed his major schizophrenic breakdown whilst a student at the Royal Academy of Music. He blamed God for deserting him in his time of need, and since then questioned all his religious beliefs that had been fundamental to his religious socialisation within a staunchly Roman Catholic family and education system. He now attended church only to appease his father since returning home to live with his parents.

In the second recorded interview William gave a very eloquent description of his conversion experience which was lacking in the other respondents' narratives: "I changed to the school just at the point of starting my 'A' levels, and after talking to some friends who I already had there who were actually part of the set up, I attended a lunch time [Scripture Union] meeting, with a very fiery talker, a business man who had just come in as an evangelism exercise. And I just underwent this experience. I think in some ways it's like falling in love, I don't know. It's a sort of switch that goes in your brain and you suddenly realise 'this is what I wanted all my life' (RI:39)...Yes. I mean I can actually remember the moment it happened. This chap was talking away and we were gathered in this classroom. And with this businessman who had come in we were just talking away about the Bible. I suddenly realised almost as if a light was flashing on" (RI:49).

According to William the milieu was instrumental in his reaction: he was a loner and at last felt that he had found a group of people that were in concurrence. "It is a sudden realisation that you belong with these people. I think if the people around you are very
friendly and welcoming and you by tradition have been a bit of an outsider, a bit lonely, a bit of a loner, I think it would be all the more emotional because you feel as if you have something in common with these other people who have this value set" (RI:55).

However, religious notions were not new to him; he had a very religious upbringing and had attended a Jesuit school. He told me “I had taken religion seriously before. I mean I attended church every Sunday and I didn't laugh at it like most other people did. But this thing was so intense it was like a, well as I said, like falling in love when you realise that the person is for you...I think this conversion experience was a very intense experience and it assumed a greater importance than anything else in my life” (RI:43).

6.3.3 ‘Christian Experiences’ (ii) Baptism of the Holy Spirit

Two respondents described their religious experience as being ‘Baptised by the Holy Spirit’. Baptism of the Holy Spirit was described in the Acts of the Apostles: “And they were all filled with the Holy Ghost, and began to speak with other tongues, as the Spirit gave them utterance” (Acts 2:4). This Baptism and the attendant gifts of glossolalia (‘speaking in tongues’), ‘prophecy’, being ‘slain in the spirit’, and ‘healing’ are still sought after by people in Charismatic churches.

Walter was very cautious when answering the questions for the interview schedule, and warily described his religious experience:

I experienced the filling of the Holy Spirit. (IS) Walter 3(ii)

At the time he was not willing to participate in a second interview and I did not press him but wrote in my field notes: “Walter is the only respondent who appears to go to a normal C of E Church and is well supported by the congregation – I need to question him further. So as to appear unthreatening I looked as if I knew exactly what he meant and that he didn't need to say more - I would want to catch anything else on tape.” Fortunately my tactics worked and Walter let me know through his key worker that he would like to help with my research. He said to her that, “the experience of talking to me was a good one”.

In the second interview he recounted what had happened to him: “I went on the first Alpha Course that was held at St [Church name] and I think I definitely had an experience in the Holy Spirit (laughs). I remember somebody saying to someone else ‘what’s happened to Walter?’ So I think I was probably sort of more excited about things” (RI:289). He had spoken previously about his mental illness causing excitability, so I was interested to know if this being “more excited about things” was
different to the manic phase of his illness. “Oh yes this was different; I mean this wasn't an inappropriate excitability” (RI:291). When asked to describe the difference he said; “Well I think it is partly something of control. I think that if you are excited in the Spirit you don't sort of get carried away. Whereas, if I was ‘high’, the excitement would be to some extent out of my control. But um, maybe it is heightened awareness of things and feeling excited about what is going on, when you are baptised in the Spirit” (RI:293). I enquired if he experienced any ‘gifts of the Spirit’. “I'm not sure really. I know at least one person fell down with a bump, but I didn't. I didn't speak in tongues” (RI:299). When asked what it felt like he replied, “It was like an inner experience... it's gone. I think I am going through a difficult patch at the moment” (RI:313).

The second respondent in this category was more difficult to comprehend when she described her experience.

*When I was four years old I had a Roman Catholic au-pair who took me for walks and told me that my parents were Protestant and that there are lots of other religions – Baptists and Charismatics. I went through into a stream and talked in tongues. I baptised myself and I was baptised in the Holy Spirit in one go. My au-pair got very upset because I got wet but she said that she would pray. It was probably triggered by a sermon. We went to a cold evangelical church. She spoke of other kinds of churches and ecumenical experiences.* (IS) *Hannah 3(ii)*

Interestingly both these respondents had very similar religious profiles: both attended church, (Walter - Church of England weekly, Hannah - Charismatic Free Church) several times a week; both were brought up religiously at home; both prayed ‘often’; both got comfort from their religion; and God was important in their lives (Walter ‘10’, Hannah ‘9’). Unlike most respondents both knew many people in their congregations, and had discussed their mental illness with church people who had been helpful. This may reflect the kind of churches people who speak about being ‘Baptised in the Spirit’ attend.

### 6.3.3 ‘Christian Experiences’ (iii) Baptism

Only one woman talked of being “Baptised” as her religious experience.

*When I was drunk and the after effects of taking tablets, I couldn’t understand what people were talking about. I went to church and christened myself. It was just before I became ill.* (IS) *Beth 3(iii)*

Although Beth did not show any signs of distress while filling in the interview schedule
she became very agitated after the interview when she spoke to her key worker about "someone talking to her about religion".

However, on subsequent occasions, after I had been to see her to apologise for upsetting her, she sought me out to talk to me and had forgotten her upset. Apparently speaking to me had brought back very bad memories of many years before when she had become seriously mentally ill. She was most concerned that she had done something very wrong going into the church. I was never able to ascertain what she had done or why. The experience obviously had religious significance for her despite associating it with being drunk and taking tablets.

6.3.4 'Physical Sensations' (i) 'High'

Three respondents portrayed the sensation of feeling “high”: two specified that this was related to their mental illness, one as a positive feeling but the other negative.

*When I was ill I went 'high' and felt great emotional love about the human race. I felt that the world was to do with love.* (IS) Jack 4(i)

*It was as a part of my illness. When I am manic I get a religious 'high'. I am aware of the Devil's presence. I feel that I have to fight the good fight. I play down religion in the normal course.* (IS) Julia 4(i)

**Jack** described being ‘high’ as part of his ‘bipolar disorder’, which was interesting rather than upsetting for him. He described his feelings when he had this experience: “I was high, that’s my bipolar disorder. So I was in a manic phase. I was aware of it but I couldn't control it. My heart was beating a lot. I was smoking a lot of cigarettes, and drinking a lot of coffee. I've just got all these thoughts and they start racing around in my head and I just can't stop it” (RI:33). Jack was not religious, did not go to church and rated the importance of God for him as ‘1’.

However, being ‘high’ for **Julia** was a very painful experience because it was when she felt depressed, although she said that she never recognised the symptoms at the time. When she was well she could analyse her feelings: “Well, each time I'm ill I get religious ideas, but um I think it's kind of clutching at straws. Looking back on it now, at the time you think it's real. But I think when you go through a religious ‘high’ it's kind of like you are ‘high’ anyway, but inside you are totally depressed” (RI:42). She was religious and attended the service-users’ church weekly when well, but felt angry that people would not take seriously her religious ideas when she was manic and in
hospital: “it would help if people would talk to you, rather than dismissing you as somebody who is crazy, and not worth speaking to. You need somebody to talk to you in a reasonable, calm reassuring manner and that doesn't happen” (RI:42).

Stephen aged 26-34 years was not religious and had never attended a church. He was not willing to engage in a second interview so I could not find out if he associated his experience with his illness.

It was like a tremendous ‘high’. I felt very ‘high’ and airy. It went on for several weeks. (IS) Stephen 4(i)

6.3.4 ‘Physical Sensations’ (ii) Smell
Hardy (1979:43) received only thirty-three examples of people experiencing ‘smell’ out of the first 3000 experiences sent to him, but felt that they may be more numerous when he read a Booklet entitled ‘The Odour of Sanctity’ which contained fifty-eight examples. The example he quoted was of “wonderful garden flowers”, which may well have had the essence of “sanctity”. However the odour my respondent Fred smelt could not: he smelt “the sewers of Hell”.

I smelt the sewers of Hell, and was visited by the prophet Elijah. The Devil gave me a warning. (IS) Fred 4(ii)

Fred had been admitted to a locked ward in a London psychiatric hospital and when shown into the dormitory told the nurse “it absolutely stinks in there, I'm not going to sleep in there” (RI:26). He said that the small room he was given started smelling after a quarter of an hour: “Sewerage. Terrible, terrible sewerage. It was the worst smell. I've never smelt anything like it. It was terrible. And God told me that I had smelt the sewers of Hell” (RI:28). When I asked how he knew it was a religious experience he told me “God tells me. God tells me. I understand. ... I don't hear voices. It's a voice within my own head, if you know what I mean, direct from Heaven, from God. Direct line straight into my brain” (RI:48). Elijah visited him on another occasion in another hospital when he was “very distressed”. “I spoke with the prophet Elijah. He had a waxed moustache, twisted, going like that. A twisted wax moustache. ... And a beard yeh. Full beard. And long greyish hair” (RI:72, 78).

Fred had become interested in God while in hospital through listening to Christian Heavy Rock music. “And when I played them it really made me think there really is a God” (RI:144). He cut an impressive figure dressed all in black with a very large silver crucifix around his neck and large religious rings on his fingers. He declared himself to be religious and that God was very important in his life ‘10’, but he had not been to
church since he left the Boy Scouts fifty years before. Fred did not need institutional
religion to have a relationship with God, and I felt that any congregation would find him
disconcerting.

6.3.4 ‘Physical Sensations’ (iii) Hear
Two respondents felt that they had heard Jesus speak to them:

*Sometimes it's like someone talks to you – sounds like Jesus. It makes me think more about Jesus.* (IS) Daniel 4(iii)

*When I was ill, mentally, I thought I heard Jesus telling me to get a tattoo done two years ago to prove that I believed in him.* (IS) Angus 4(iii)

Their religious profiles were very similar: both were male; neither attended a church
although both had some Christian socialisation - Daniel had attended a Free Church
within the last five years despite not being brought up religiously at home, but left
“because there were too many people” (IS), and Angus stopped going to a Roman
Catholic Church with his parents when he left home; to the question of religious identity
they both responded ‘don’t know’; God was not important in their lives (‘5’); both were
young - Daniel 26-34 years and Angus 18-25 years. Given their disinterest in matters
religious it was interesting that when Daniel heard a voice he identified it as belonging
to Jesus, and Angus thought that Jesus had told him “to get a tattoo done” (IS).

Chloe had no religious input: she did not come from a religious background and had
never attended a church service. Her religious identity was ‘don’t know’ and God was
not important to her (‘3’). However she gave a religious interpretation to the experience
she had, possibly because she felt that she had communicated with the dead:

*When my Nan died I was tenish and I didn’t know that she had died. I thought she spoke to me although she lived in Devon to say that she is OK. Next day I found that she had died. I still speak to her now if I feel low.* (IS) Chloe 4(iii)

The last respondent in this category was a highly intelligent young man, who thought
deeply and spent his free time listening to music and enjoying “fine arts” (IS).
Unfortunately he was most unwell and his thought processes were very complex: every
question on the interview schedule became a difficult issue because he had first to
understand the concepts of ‘religion’, ‘God’, ‘church attendance’, ‘the meaning of life’
and 'death' before he could worry over an answer. I wrote in my field notes: "Dylan had great difficulty putting boundaries around any question so that each one was an enormous hurdle first to be understood and then answered". His experience was obviously very significant to him, but he would not engage in a second interview so I could not investigate it further:

When I started hearing voices I could hear deep speaking coming from the devil people and pointing down I could hear higher notes coming from upper angelic voices. They were talking amongst themselves and me. (IS Dylan 4(iii))

6.3.4 ‘Physical Sensations’ (iv) Heat

Although this experience could have been put under other categories such as ‘Presence of the Supernatural’ or ‘Christian Experiences’, the element that stood out most strongly to Megan was the feeling of heat.

I woke up in the middle of the night and felt a presence at the end of my bed. My whole body was glowing and hot, including my feet, and everything was yellow. (IS Megan 4(iv))

Megan was woman in her sixties who had suffered with mental health problems for many years and attended a Charismatic Free Church more than once a week. She was a talented painter and stated that she had been a Christian for two and a half years, although she had been interested in spiritual matters for a long time. “I didn't have a Christian upbringing although I was confirmed and I used to potter off to Church once or twice on my own for communion, but not regularly. But when my husband became so desperately ill, and died within three months, I began to realise that I was supported by people who were very strong in their faith, and that was when I started reading” (RI:6).

She decided to go to a particular Charismatic Church of England which she described as “visiting a banquet and being fed properly, and my turning point was going to that church” (RI:138). It was during this time that she had a significant religious experience. “I woke up in the middle of the night. I always tend to have cold feet, and when I'm tense and stressed my feet are so cold. Even if I have a hot water bottle and an electric blanket and two blankets on them they are still cold. Well it wasn't that bad that night but they weren't warm, they were cold when I went to bed. And I woke up in the middle of the night, and suddenly, the old, old story which one has read many times but it's never for you, is it? But it was for me this time. There was this bathing of golden light at the end of the bed. There appeared to be a figure there, my feet were warm, in fact my
whole body wasn't just warm it was hot and my feet were hot and I was just lying very straight, in true Alexander Method fashion, and I thought this is very extraordinary, what's going on? And that was it. And since that day my whole body mechanism has changed. That was just over two years ago and I hardly get angry. I hardly get irritated” (RI:138). I asked if her feet were still warm. She laughed and said “they seem to be” (RI:142).

Although Megan mentioned that she had read about religious experiences and had been attending a church in which such occurrences would be accepted as normative, she did not manufacture the incident or the effect that it had on her life. The Christian culture gave her a framework within which the profound experience could be understood.

6.3.4 ‘Physical Sensations’ (v) See

Six respondents mentioned ‘seeing’ objects and people.

Henry was in his late fifties and described himself as religious, although it brought him no comfort. God was very unimportant to him (‘1’). He said that he ‘had been brought up religiously’ but had never attended a church. Although his experience was out of the ordinary it was surprising that he interpreted it as being religious.

My great grandfather lived at Southend and I saw the sea on fire. For six months it left a great impression. (IS) Henry 4(v)

Mike was a young man who attributed his experiences to being mentally ill after taking non-prescription drugs. Again it was surprising that he ascribed them a religious significance.

When I was ill I felt that I was possessed – it was very frightening. It was probably drug induced. I saw images of things like murders. I haven’t had any experiences since becoming well. (IS) Mike 4(v)

Morris described himself as religious and said that God was very important to him (‘10’). However, he had not been to church since he stopped going more than forty-five years before. His experience may have been during the time that he said he was “forced to go to Sunday-School” (IS), so he gave a spiritual interpretation to it. It was obviously very significant to him as he still recalled it all those years later.

I have a memory when I was under ten and was standing on a wall and looked up at the sky and saw a silver spoon. I felt it was a spiritual experience. (IS) Morris 4(v)
The experience related by Joan was difficult to understand, but she described at great speed what she had seen and the content was not strange to her.

\[ I \text{ have seen a man who disappeared into thin air and spoke French. It was an eye opener. It made me feel if I did die I wouldn’t be alone because He cared. I thought I was dying. I think it was like a person who cared like a vampire. Energy. (IS) Joan 4(v)} \]

She described herself as ‘not religious’, and when asked how important God was in her life replied, “My God within me is important” (IS), and marked (‘8’) on the scale. She did not ‘get comfort from religion’ and had never been brought up ‘religiously’; however she said that she attended a religious group when she was sixteen years old: she belonged first to a Black Magic Group then a Grey Magic group, but left because she became annoyed at the sexual demands made on her by the other members. I was unable to ascertain whether her experience would have been understood within a Magic framework or whether it was as a result of her mental illness.

Sophie was a Spiritualist and explained that her religious experience was normative within her church; however she did connect it with being mentally ill at the time.

\[ I \text{ have seen ghosts – several throughout my lifetime. I believe in evil spirits. I saw a male person standing on the window ledge – outside trying to get in, dressed in black. I sensed evil and it wanted to come in. I had just come out of hospital. (IS) Sophie 4(v)} \]

Susan also spoke about an experience she had when mentally ill at the age of thirty-two.

\[ W\text{hen I was very ill I thought that I saw a guardian angel – I was getting worse and worse. I have a little picture of Jesus and Our Lady and when I felt that a bad force was happening I put the Holy Picture under my pillow. I woke up with a start and saw in the dark a very small guardian angel. I saw a witch. After confession a heat came through me and I didn’t feel frightened. (IS) Susan 4(v)} \]

She seemed to be trying to make sense of her illness, and seeing it as a battle between good and evil used her guardian angel to protect herself by putting a Holy Picture under her pillow.

She described herself as a Roman Catholic, but she had not been to church for over five years – she said, “We went when all together as a family but I did not want to go alone” (IS). She had a little crucifix by her bed which she felt protected her. She only prayed “in a crisis” (IS).
I did not ask Susan for a second interview as she appeared to find the first one stressful as it brought back bad memories. This decision was correct as she became upset when she spoke to her key worker after the interview - her key worker said that she was relieved when she found out that it was me who had talked to her about religious matters, as she was aware of the research and supported it.

The experiences in this category were characterised by fear and forces of darkness. Many of the respondents identified them as being part of their mental illness. None of the narratives would have been normative within mainstream Christianity.

6.3.4 ‘Physical Sensations’ (vi) Feelings of: peace; calm; and “nice”
Feelings of ‘peace’ and ‘calm’ were reported by two respondents, both after experiences associated with religious events, and one respondent felt that his experience was “nice”. Amanda had a feeling of calm that came during a Confirmation Service, and Kevin felt peaceful after a period at a Christian healing centre.

In 1957 when I was confirmed at the age of eighteen, I was confirmed because I wanted to be married. I had to be baptised in February and married in March and confirmed in April. When the Bishop put his hands on my shoulders I had a feeling of calm and it remained there for weeks.” (IS) Amanda. 4.(vi)

I felt very different, very peaceful after being at [place]. (IS) Kevin 4(vi)

The experience related by Matt was very difficult to comprehend, but whatever had happened to him was reported as “a nice feeling”.

I send things right around the world. People can hear whatever I say. Wind came in and there were birds at the back. I was with my sister and someone said “are there bats here”. “Don't be so silly”. It was a nice feeling. (IS) Matt 4(vi)

Although Matt appeared quite confused, he obviously remembered the experience he had related as being ‘religious’. Therefore in the second interview I tried to glean what he understood of his experience.

You told me that you had a religious experience.
I did.
Can you tell me about it?
Well it was um like er when we was moving house, moving backwards and forwards I could hear meself, in me head, throwing messages round the world. So I didn't think anything of it.
How old were you then?
I was about fifty-eight. And me brain 'urts. And when I gets these turns all the time with no let off, if I am saying anything dirty or anything like that, it's not very nice like.  
*What happens then?*  
It goes round the world and it comes back to me, whatever I say. I'm not joking.  
*Have you ever had any other religious experiences?*  
Well no I haven't.  
*Only then.*  
Yeah, only then.  
*Do you believe in God Matt?*  
I do yeah.  
*And have you always believed in God?*  
I always believed in God.  
*Were you brought up in a religious family?*  
I was brought up in a convent.  
*Why was that?*  
Because me mother couldn't have me because she had a heart attack. It was in the wartime. **Matt** (RI:21-40)

**Matt**'s religious experience was evidently an event that he remembered, but he was unable to express in words what meaning it had for him, if any. All he could express was the pleasant visceral feeling that remained with him.

### 6.3.4 ‘Physical Sensations’ (vii) Hallucinations

Two respondents associated their hallucinations with their mental illness: **Peter** had been in hospital at the time and **Oliver** noted that they had been “part of my mental illness” (IS). Of the three respondents who experienced hallucinations one found them very frightening, whereas the other two appeared not to be upset by them. All three described themselves as ‘religious’.

**Peter** was a delightful young man in his early thirties who regularly took non-prescription drugs and was often in conflict with the police. I was surprised to discover that he had a religious upbringing and attended a Roman Catholic Church once a month. He ‘got comfort from his religion’, prayed ‘sometimes’, and God was very important in his life (‘10’). Although he did not describe the content of his hallucinations he felt they were religious.

> In hospital when I was ill after taking lots of drugs I experienced lots of hallucinations. (IS) **Peter** 4(vii)

**Ryan** had not been brought up religiously and had not been to church since he left school. He felt that he had ‘been in the presence of God’, and when he was ill more than
ten years before God had been very important to him (‘10’), but now he rated God’s importance in his life as unimportant (‘3’). Evidently he was more religious ten years before my interview with him, when he ascribed the voice in his hallucination as emanating from God. He described his experience:

When I took magic mushrooms I hallucinated a lot and I thought it was God talking to me. It was not like a conversation with no-yes. I read Paradise Lost and had experience of seeing devils. It would be frightening if I had not taken magic mushrooms – that took the chill off it. I think religious experiences are when you open your mind with magic mushrooms. (IS) Ryan 4(vii)

In the second interview Ryan was able to describe the hallucination that he described as religious, but God did not feature in it. I had to remind him what he had said on the interview schedule as there was a gap of eleven months.

I'll remind you what you said last time. “When I took the magic mushrooms I hallucinated a lot.” Do remember that now?
I can still remember basically what it was, it was the Wacky Races Cartoon. It was like Dick Dastardly.
Can you tell me about it?
I can't really remember. All I remember is everything was wacky, the pub looked like the sign was only hanging by one string blowing in the wind, and all the eyes and everything were all wacky and Elizabethan looking.
What sort of an effect did that have on you?
I wasn't frightened. It was a bit, not really scary, but you felt you had to have your wits about you. You felt you had to be on edge. The wackiness only lasted for about ten seconds. As soon as we were in the pub it was OK again.
So when you were with people it went?
Well, I was in the car with a friend and we just drove from taking the mushrooms about half an hour before. We drove to this pub and then it was all wacky. That's all I remember of it really.
Have you had anything like that again?
No because I haven't taken any more.
Did it have any effect on you?
It had an effect on me of making me hallucinate funny faces on cars and stuff like that. Sort of like a sideline of the wackiness. Like when I was a kid, I had this book on cars which had faces on, so it was very 60s ish. We went to this restaurant in [place] with my step father and two friends who live in California, and they are both hippies, and they said they hadn't seen anything like me since the 60s. This was 1982. Ryan (RI:25-36)

Oliver was a well-educated man who had been an accountant, but his illness took a heavy toll and he said that he now spends his free-time “sleeping” (IS). His hallucinations had a religious content.

I experienced hallucinations of spirits that frightened the life out of me. I have seen writing in the sky as a message from God – all a
He was a Roman Catholic who said that he had been to church within the last five years: "I go for comfort once in a while. I don’t usually need comfort – God is looking after me in the form of the Holy Spirit, the stronger spirit is on my side" (IS). God was very important to him (‘10’), and when asked if he felt that he had been in the presence of God replied “Yes. I was going to jump off [name] Bridge but He spoke to me and blew me off” (IS).

He had agreed to a second interview, but later changed his mind and told me that speaking about his religious life brought back very frightening memories and images which he did not want to remember.

### 6.3.5 ‘Extraordinary Experiences’

The last category of ‘Experiential Experiences’ was ‘Extraordinary Experiences’, and they were described by ten respondents under the headings of: ‘Out of Body’; ‘Near Death’; ‘Healing’; and ‘Warning and Déjà Vu/Premonitions’.

#### 6.3.5 ‘Extraordinary Experiences’ (i) Out of Body

Although Timothy described himself as religious his profile showed no factors that would support this. God was unimportant (‘4’), but he said that he ‘prayed in times of crises’: “I prayed like crazy when I first became ill and heard voices but He didn’t help” (IS). However, he added the rider “Actually, He probably has over the years” (IS). It was surprising therefore that he considered what he said “may have been a dream” (IS) as a religious experience, although I noted, “Timothy had a clear grasp of the Christian religion through people trying to convert him” (field notes).

> I had an out of body experience. I was in bed asleep. All of a sudden my body was hurtling out of bed and going down a vortex, blue and spots of different colours. I said SHIT and woke up in the body and it never happened again. It was a year ago and was a bit pleasant and a bit scary. I may have been dreaming. (IS) Timothy 5(i)

Lottie was a young woman in her late twenties who said she did not have a religious upbringing but used to go to Sunday School when young. She said that she “would go to church if she had someone to go with. Sometimes I stand outside a church but I don’t feel that I can go in alone” (IS). She said she was a religious person and got comfort from her religion: “it makes me feel good to have something to believe in and someone watching over you” (IS). It was understandable therefore that the strange experience she
could remember after so many years was given religious meaning.

When I was five I was walking down the stairs and was floating towards the ceiling. I felt I was right up to the ceiling. I felt very relaxed, good, never felt so at ease. I went downstairs and lay on the couch and felt wonderful. I never saw my own body, just felt floating upwards. (IS) Lottie 5(i)

6.3.5 ‘Extraordinary Experiences’ (ii) Near Death
Neither of the respondents who described having had a near death experience was ‘religious’, and they rated the importance of God in their lives as (‘3’) and (‘4’). However, both had attended a Church of England more than five years before so were aware of the teachings of the Christian faith. They both regarded their experience as religious.

I went to Thailand about 7 years ago and had an experience at a waterfall. I got sucked under the water and thought that I was dying and became extremely calm. It was a near death experience. I came above the water gasping for air. I found out that two years before I went someone had drowned there. I was not panicking, rushed or upset. I was totally calm. (IS) Ralph 5(ii)

In 1956, I suffered a compound fracture of my femur playing football and I needed an operation, but I don’t remember much. It was suggested that I go back to Bristol on the train to hospital and I nearly died. I felt the couch floating in the cloud in the sky. My mother said that I nearly died. (IS) Julian 5(ii)

6.3.5 ‘Extraordinary Experiences’ (iii) Healing
The four instances of healing mentioned as religious experiences by the respondents were all attributed to God in the singular: three were Christians and one a Hindu.

Tyler gave two instances of his religious experiences, and the one about healing he considered to be an everyday occurrence and mentioned it in passing:

I laid my hand on someone’s shoulder and it clicked back into place and was healed. (IS) Tyler 5(iii)

The other respondents were much more deeply affected by their experience because two related to their own healing and one to the respondent's father.

Betty was a fervent Hindu and visited the Temple more than once a week. Her
command of English was limited so she found it difficult to describe her experience.

"I was very poorly for three years and lost my memory but it came back again. It was a great shock, like a miracle. I didn’t know anything about it." (IS) Betty 5(iii)

She was able to explain more when asked how important God was in her life. She said very important (‘10’) and added “He cured me. If I didn’t believe in him I don’t where I would be now. It is a real blessing from God that I am cured now” (IS).

Amy told me that she had a drug and drink problem, and in 1994 aged twenty-four was very ill and suicidal, “But something kept pulling me back to the church, just to go once to say goodbye or something like that. Something just tugged me back” (RI:199). It was there that she experienced her healing:

When I became ill I went to church and one strange thing happened. One day the drinking was bad and I had been up most of the night. I went to church and thought that everyone would have a go at me. I felt awful and couldn't see the cross. ‘Say floor’, ‘say slats’. I said if God could make me better I would believe. I went out of the church and realised that I was seeing again. I could see again and there was no tremor. I told someone what had happened and she said it was the power of God. (IS) Amy 5(iii)

In the second interview Amy relived her experience and said, “I totally believed, because nothing could have made me better. No amount of drugs could have got me through that. And I was just stunned, absolutely stunned. And to this day I do believe it was a miracle” (RI:199). When asked how talking about it made her feel she said, “It makes me glow again. It does make me glow. I haven’t mentioned it to anyone else since I talked to you. But it does make me glow. I do believe there is a God. I believe in him as a higher power, as a support I suppose” (RI:203). She had been afraid of talking about it: “at first I thought that if I explain anything like this to somebody they are going to laugh, and they will think I am joking, that I am way out... And like I say I don't talk to many people about it because I think it is very hard to believe” (RI:199).

The last respondent who talked of healing was Agnes whom I had been warned to be careful with – to everyone’s surprise she willingly filled in the interview schedule but would not countenance a second interview. She related at great speed an experience of her father’s healing, which she attributed to answered prayer.

Last year my father had a stroke. Waking up in the dark I saw my father in a dark ward, everyone was ill. A silent hand glowing from the Holy Spirit came down on his head. I heard a metallic boom. His
soul left his body. Tell the nurse he is healed. I phoned the next day. I had been in hospital and said that Christians had prayed for him. He was discharged five days later. I feel Christ healed him. (IS) Agnes 5(iii)

6.3.5 ‘Extraordinary Experiences’ (iv) Warning

I was very surprised that Josh should have described his experience as religious as he was a convinced atheist, never attended a religious service, never prayed and marked the importance of God as not at all important ‘1’.

The only reference to religion for him was “a wax figure of the Madonna and child which I felt saved my little girl’s life. It melted out of the candle I was burning, and I thought it was a sign that she would live.” His life was full of signs and warnings but no God. He did not say what he felt was responsible for the strange happenings in his life but ascribed religious significance to them.

I thought that I saw the death figure once. It looked like the old man with a scythe. I went out for a walk one night in the Shetlands. I looked around and saw the Grim Reaper. I thought ‘don’t run’. As I walked I came to a quarry. If I had run I would have gone over the edge into the quarry. I don’t know if that was a warning or someone trying to kill. It was twenty years ago. (IS) Josh 5(iv)

6.3.5 ‘Extraordinary Experiences’ (v) Déjà Vu/Premonitions

Tyler attended a Charismatic Free-Church where religious experiences were the norm. However, in the second interview he said, “Well I don’t really like talking about them too much because I get classed as schizophrenic, but once you become a Christian you know these things are real” (RI:24). He was uncertain whether he should speak to me for that reason, and would not have done so if we had not worked closely together for several years and he trusted me. He related an experience he had at work:

I have had lots of déjà vu – second chances. At work I experienced a premonition of someone coming to choose a tile. It took a long time to sort out the problem. This person came in one year later and I recognised her from my premonition and knew what she wanted and therefore could sort out her problem instantly. (IS) Tyler 5(v)

In the second interview he did not refer to this experience but spoke about his very close relationship to God, his many answers to prayers, and strange coincidences and events to which he gave a religious interpretation.

We conversed for ninety minutes and Tyler kept me engrossed. Although he left school
at sixteen and was told “you will never get a job because your exam results weren't good enough” (RI:306), he was able to give very clear insights into the way Churches understand mental illness and the Health Service Christianity. His thought processes were very clear, which made it difficult to reject his extraordinary stories as being unreal.

6.3.6 Reflexive Experiences
The last category was of experiences that were introspective and reflected the effect that religion had on the lives of the respondents.

The simple statement that Alan gave of his religious experience did little to portray the enormity of the effect that ‘his call to the priesthood’, and subsequent rejection, had on his life.

*I thought that I was going to be a priest, I felt that I was told to do it. I was called by God. It was an inner experience. (IS)*

Alan was near retirement age and said that he had not been to church for many years: “I lost the urge to go when they turned me down” (IS). He had been brought up religiously at home which seemed to have been instrumental in his decision to apply for the priesthood.

*You said that you were brought up religiously at home.*

Yes I was, by my grandmother. My parents were active Christians but nothing very big. Rather Tory Party at prayer.

*Church of England Tory Party at prayer?*

Yes. But my grandmother was very keen that I should go into the church. Her husband had been a parson.

*In the Church of England?*

In the Church of England yes. So there was no doubt about it I was rolled very fast. I was very fond of this grandmother and we lived in her house during the war, and she used to come to us for Christmas and things like that. So in that sense I had a religious upbringing, yes. Alan (RI:22-27)

However, his rejection by the Church for the priesthood not only caused him to stay away from church but according to Alan, “The medical illness history starts from there...I suppose the honest me inside looks back at it with anger, but I would never show it, because I don't think it is a thing to be angry about. I know I am angry about it but I still don't think it is the thing to be angry about” (RI:77).

He described himself as ‘religious’, prayed ‘often’ and said that he ‘got comfort from his religion’. God was important to him (‘8’), but nothing would take him back to institutional religion.
When Kate was asked if she had ever had a religious experience she expressed how religion affected her life.

*I thought that I was spiritually gifted. I thought that I was entering into another world. I have believed for years that I am spiritual deep down inside.* (IS) Kate 6

She said that she was religious but had not attended church since she was at Sunday School as a child: “I find church is too snobby, especially St. [name] Church. Also I feel that I am not good enough, not a moral person” (IS). She felt that she had been in the presence of God “many a time. I thought that God was controlling my destiny” (IS). He was very important in her life (‘10’), but she never prayed. She had a crucifix which she “definitely” (IS) thought protected and helped her.

Emma found a sudden change in the way she thought about herself after help from the hospital chaplain.

*[Name] (Hospital Chaplain) used to visit when I was first ill. I had terrible feeling towards my daughter. I thought that I was an evil person. [Name] sat with me for a long time and made me see that I was not an evil person but only had evil thoughts. It was a sudden breakthrough and since then I have got better.* (IS) Emma 6

She attended church once a week, and went to the weekly coffee morning and discussion group held for people with mental health problems. She discussed her religious life with the Consultant, but said this was 1-2 years before the interview because “I got so much better and haven’t needed to recently” (IS).

Evan belonged to the Jehovah’s Witnesses and everyone knew about his religious views: he was totally absorbed with all things spiritual. However, it was difficult to know how much was his church’s teaching and how much was his own embellishments: “Well, we believe that the Kingdom is a government that is going to rule instead of all these governments that are ruling now. There’s going to be a new one or a world government, maybe a universal one, I believe personally that there will be, and there are aliens involved from other planets as well. But the Witnesses don’t necessarily hold to that, but they do believe there is going to be a new government on the Earth formed by Jesus himself and the Apostles will be there and all that are dead or those who die in union with Christ will be raised up at the first resurrection. And at the end of the thousand year reign of Christ, the Kingdom, there will be another resurrection of the not so righteous and anyone that might be put back to death and destroyed (RI:31)...You
must be careful with me because I'm telling you things that I know but are not necessarily the views of the Witnesses” (RI:43).

*I firmly believe that God is going to do something about wickedness. I go to the Jehovah’s Witness Hall. I think that I have more advanced knowledge than they do about an alien race. Aliens may destroy the wicked when they come. (IS) Evan 6*

I had worked for many years with Rachel, who was in her fifties, but we had never discussed any religious matters. When asked if she had ever had a religious experience she responded:

*Every time that my grand-daughter comes to see me I think that she is a blessing. (IS) Rachel 6*

She described herself as ‘religious’, but she did not attend a church service, although she said that she would like to go to the Harvest Festival Service if she had someone to go with.

In the second interview Rachel was able to explain why she thought her feelings towards her granddaughter were spiritual.

Having [name], somehow it is sort of gives you like an inner peace. *Why?*
Um I don't know. Somehow you feel blessed. It is a job to explain really. *And do you feel that every time you see her?*
Yes. I feel sort of extremely lucky, and somehow I feel more at ease with myself. *Why do you think that would be?*
It is just her sort of belief in you. You know she looks at you and it is important to her sort of how you treat her.... she is such a source of joy that mm you didn't think you would ever have. And she just gives you this sort of peace. (RI)

As the second interview progressed Rachel started revealing a spiritual part of her life which surprised her. I asked if she had ever had any other religious experiences.

*Have you had any other experiences in your life which you think were spiritual?*
Um...it might sound daft, but how I have survived. *And what would you put that down to?*
Well as I would put it, Him upstairs looking down on me. *And have you felt His presence looking down on you?*
Yes, I think I do. *How would you describe that?*
As if you are the only one that matters. *Have you always felt that 'Him Upstairs' has been looking after you?*
Yes.
In what way?
Well somebody must have been looking down on me, because sometimes the, for want of a better word, the beatings I've had, and you know sort of not only by the hands but by the feet as well, I think you have got to have somebody whose looking down on you and protecting you so that you can get up and um carry on.

*Did you ever talk to Him?*
I have.

*And do you still?*
Yes.

*How often do you do that?*
I think it is most days really. Do it sort of subconsciously. (RI)

It transpired that Rachel took herself to Church and Sunday-School at the age of eight but never told anyone, not even her beloved Granny, where she had been. In fact I was the first person she had told about this happy part of her childhood. “It was fun. We sang songs and had like a little Bible reading, and then sort of put up things on the board, and then we'd have to draw pictures or something like that. And even have sweets and things like that. And it was happy. Everybody was happy.” (RI)

She then told me that before she moved she used to clean the local church on a Friday night, because she did not like the services: “And they start hugging one another and I can't stand it. Not at the moment.” When asked why she cleaned the church, she said that she wanted to do something for the church “I suppose as a thank you, I suppose to God.” (RI)

I asked her if she had ever thought of herself as religious and she said “No, not really.” I asked “Would you now after what you have told me?” She replied “Yes, I suppose I am. Yes. It just makes you realise how you do think and you think like that every day, without realising that you are thinking like that every day.” (RI)

God – ‘Him Upstairs’, was evidently central to her life but she had never verbalised her thoughts. “I am selfish, I keep Him to myself. Well, perhaps selfish is the wrong word. It's like thinking that He belongs to me.” (RI)

I asked about her childhood.

*Would you blame Him for all the awful things you suffered as a child?*
I have blamed Him, yes.

*And what have you said to Him?*
Um that He is sort of rubbish. And then by the end of the time of having a go I change me mind. And that's why I think I am selfish. (laughs)

*How do you envisage 'Him Upstairs'?*
I see him as a man, but I hope he isn't a man. A sort of cuddly person with sort of great big long, long elongated arms that gets right round you, sort
of thing. Um (hugs herself with her arms)
Does He have a face?
No.
Just arms.
Just these arms.
Can you sometimes feel these arms?
Yes you can.
Can you feel them now?
(Whispers) 'Yes' (RI)

6.3.7 'Would Not Relate Experience':
The four respondents who said that they had had a religious experience but would not
describe it fell into two groups: those that were evidently ‘very religious’ (Importance
of God ‘10’) and one who was less so (Importance of God ‘4’).

Of the three religious respondents, all attended church at least once a month; prayed
‘often’; rated God as very important in their lives (‘10’); got ‘comfort from their
religion’; were ‘brought up religiously at home’; and had ‘felt in the presence of God’.
The two religious male respondents were unknown to me, and I conjectured that they
did not want to expose themselves to possible ridicule as I was an unknown entity. The
female respondent knew me well but belonged to the Strict Brethren and divulging any
personal details was painful for her: all her questions for the interview schedule were
monosyllabic.

The fourth respondent described himself as religious, attended church at Christmas and
Easter and got comfort from his religion, but he had not been ‘brought up religiously at
home’, had not ‘felt in the presence of God’, ‘never prayed’ and rated God’s as
unimportant (‘4’). He did not know me, and had been mocked by the other young men
in the workshop when he came to fill in the interview schedule because of the nature of
the study. It was understandable therefore that he was unwilling to share sensitive
information with a stranger.

6.4 Discussion
The majority of the religious experiences recorded in this chapter could have been
narrated by any person who was brought up in a Judeo/Christian culture. They speak of
answers to prayer or pleasant experiences that they attributed to the beneficence of a
higher being.
Although many respondents described themselves as religious, and that God was important in their lives, very few attended a place of worship or took part in institutional religious practices. The reason for this was generally because of bad experiences they had suffered within religious communities. This will be looked at further in the next chapter.

James (1902/1985:380) described “Ineffability” as a characteristic of religious experience, which was an interesting concept when it came to analysing the experiences of people who are mentally ill: when does a strange description become the delusions of a madman? I had the benefit of interviewing each respondent and was therefore able to record other characteristics as well as just their words: speed of delivery; body language; concentration; comprehension. Hugh concentrated and spoke slowly, searching for words to explain to me his experience, and there were no signs of irrationality just difficulty in conveying his thoughts and memories. Agnes on the other hand was jumping from topic to topic at great speed. I had no doubt that she was relating her experiences to me as she remembered them, but she had so much information tumbled together that the train of thought was lost. Hugh’s experience was ineffable, Agnes’s experience was not.

To someone unfamiliar with the Christian religion some of the practices in a Pentecostal Church would be considered very abnormal, and the experiences described by the charismatic respondents could be dismissed as delusional. It was important therefore not to dismiss the narratives of those who held diverse religious views, or whose construction of reality was not normative within mainstream Christianity, simply because they belonged within a different religious framework. When Morgan first told me that he had seen the top half of his Granny I thought he was fantasizing, because he was very serious and clearly not trying to fool me. It was in the second interview that I understood that such events were normative in the Spiritualist Church. However, Sophie, another Spiritualist woman, who had seen ghosts throughout her life and believed in evil spirits, did associate her experience of seeing a man dressed in black on her window ledge with the fact that she had just come out of hospital. Within the spiritual realm nothing can be measured accurately; very often it has to be the person concerned to discern what is outside their normative practice.

This point was stressed by Julia who was very clear that her religious experiences when mentally ill and ‘high’ were not those of when she was well. However, she did not want them to be dismissed because they were part of her mind and self-identity, and she was
upset that staff would not talk to her during this time to help her sort out her thoughts.

Fear was a dominant factor in several of the narratives, and was often associated by the respondent with their mental illness. Mike felt he was possessed and saw images of murders, and Morris was frightened by people “projecting things onto me”. Oliver realised that the spirits he saw that “frightened the life out of me” were due to his mental illness. Hardy noted 4% of his respondents related fear or horror in their experiences. It was difficult to quantify the number of my respondents who talked about fear because it came in different parts of the interviews and in different forms, usually much less dramatic than the above. However, over one fifth of my respondents who related their experiences to me (N=63) mentioned some element of fear.

Fear was spoken of in the narratives of the battle between Good and Evil that some respondents felt they were waging. Julia became aware of the Devil’s presence and “had to fight the good fight”. When she was well she saw this as part of her illness but at the time it was terrifying. Susan saw a witch and had to protect herself from “a bad force” with a religious object. Again she related this to her mental state at the time. Lucy related at length a terrifying experience she had when feeling “oppressed and persecuted.” Certainly for some mentally ill people the torment and confusion in the minds takes on the symbolism of a spiritual battle.

Many of the respondents commented that they did not discuss religion because they did not want something so precious to them to be dismissed because they were mentally ill. Only four respondents out of the total sample of one hundred related that they had been upset by talking about their religious lives, usually because it brought back fearsome memories. Inevitably the reactions of some would not have been relayed to me. What was notable was the large number who said, not only to me but to members of staff, how much they had enjoyed speaking about their religious lives. In one workshop the staff commented how much more lively and responsive their clients were after the recorded interview.

However, I was unprepared for Lucy’s comment. During the second interview she related at length an experience which she had never described to anyone. Having been her key worker for many years I was astounded that such a momentous experience had never been mentioned when she had spoken about so many elements of her spiritual life. When I asked her why she had never told me she replied, “you never asked”. It was not said accusatorially, just a simple fact. For me it manifested the complexity of the therapeutic relationship particularly in matters spiritual: should people being treated for
a mental illness be probed about their religious notions or is it sufficient just to give them space to make their own agendas?

The analysis of the religious experiences was instrumental in understanding a small part of the religious lives of the respondents. However, there was so much more to their religious identities than simply narrating their experiences. During the second interviews the service-users related their insights into being mentally ill and having religious notions that were very valuable to them. They depicted stories of exclusion and stigmatisation, and spoke of the lack of understanding and help that they received, more within the community than within the Mental Health Service. These issues will be explored in the next chapter.
Chapter 7
Light in the Darkness?
Religious Beliefs and Practices

7.1 Introduction
Reviewing the religious experiences related to me by the service users gave a window into the religious dimension of their lives which is seldom enquired about, let alone in conjunction with their mental illness. It opened up the acceptability of talking about a realm outside the empirical scientific world which is stressed by most medical professionals.

Within the second, recorded interviews I was able to explore religious issues that had come out of the interview schedule, and looked at the idiosyncratic frameworks of understanding that the service users employed to make sense of the world around them and within. As Giddens points out, everyone develops a "framework of ontological security of some sort" (1991:44), to enable continuity of life amidst the potentially overwhelming fears and threats that assail each human being from early infancy. Each individual therefore develops tried and tested behaviours and methods to protect themselves in an attempt to gain a feeling of security to prevent the opposite state from ontological security - 'chaos'. However, people with enduring mental illness recurrently have experiences that appear to threaten this sense of security and indeed precipitate them into a state of 'chaos'.

Having looked at the service users' religious experiences it was important to contextualize them within their lives. As has been shown, religious experiences are not confined to conventional religious frameworks or institutions. In fact they seldom occur within a religious building, although they are shaped by cultural settings and experiences not least those of the dominant religious culture within which the subject has been socialised. The service users would have processed their religious experience within their own ontological framework in order to comprehend and interpret its meaning. However, unlike people without mental health problems they may have had a genre of mental illness experiences that were more extraordinary than the religious
ones, and these too would need processing within their own mental framework. For some the two types of experiences may be conflated, particularly when acutely ill, but most of my respondents when well were able to differentiate the two.

Most of the respondents who acknowledged that they had had a religious experience also identified that they had religious proclivities. This concurred with the literature (Faulkner and Layzell 2000; McKerrow and Faulkner 1997; Macmin and Foskett 2004) which pointed to people with enduring mental health problems having high ‘religious interests and needs’. The issue that no one had considered is whether one of the reasons why people who suffer with mental illness have higher than average religious interests is because they look to religious beliefs and practices to provide their ontological security. In the same way that when there is a national crisis that shakes peoples’ sense of safety, or even an international calamity such as the bombing of the Twin Towers, church congregations swell for a few weeks while people look to a higher being for protection against events out of their control that appear to threaten their existence. When no disaster overcomes them personally and their confidence returns they return to their habitual religious practice and discontinue church attendance. However, I hypothesise that people with enduring mental illness suffer personal crises that appear to threaten their existence on a recurrent, if irregular, basis, and therefore they look to a higher being on an on-going long-term basis to restore their sense of security. As one respondent commented:

We all look for something, you know, when we are in difficulties, don't we? All of us, you know. I think we all look for...help don't we? Spiritual help when we need it, yeah. .....Mmm...Like soldiers in the war they probably didn't go to church but they all ended up praying sort of thing. Didn't they? (sigh) Kevin (RI:311)6 45-64 years.

In sociological terms they use religion to create a framework that can contain their chaotic experiences so that life can be seen to have a degree of predictability, thus giving them ontological security (Giddens 1991).

Mental illness, particularly in the acute phase, can produce thoughts and feelings that rock their sense of security as their habitual thought processes and experiences become thrown into chaos by their illness. The tangible world becomes less real, and illness can

---

6 RI signifies that the quotation is taken from the second interview which was recorded. The number signifies the segment in the respondent’s file in the MAXdqa computer analysis programme.
cut off sufferers from their regular lifestyle, work and friends that might reinforce normality, so that they become absorbed into an unreal world. Once a breach has been created in the boundary between ‘real and unreal’, ‘normal’ and ‘abnormal’, ‘this-worldly’ and ‘other-worldly’, perhaps it is less problematic to seek for explanations of their strange experiences in religious knowledge, and accept religious understandings that are non-empirical, in the same way that service-users are forced to live with their non-empirical mental illness experiences. Conceivably the fact that the scientific world cannot repair their ‘protective cocoon’ (Giddens 1991) and provide them with ontological security, drives them to look for another framework to make sense of their lives: religion.

This chapter will analyse the in-depth interviews of thirty-six respondents to assess if they looked to religion to provide ontological security.

7.2 Beliefs - Spiritual Warfare

Religious life for many of the respondents was a battleground fought between good and evil, God and the Devil. It was noted in Chapter 5 that twice as many of the total sample of one hundred respondents believed in ‘the Devil’ (62%) and ‘hell’ (52%) as did the general population (World Value Surveys for Great Britain 1990: ‘the Devil’ 32%, and ‘hell’ 26%, n=1484). In fact this was even more pronounced when analysing the narratives contained within the thirty-six in-depth interviews. Twenty-five people (69%) believed in the ‘Devil’, and twenty-three (64%) believed in ‘hell’. Perhaps my respondents had a broader concept of hell as some commented that they felt that they were experiencing hell in this life: “hell on earth” (Ann: initial interview); “Sometimes I feel that I'm going through hell now, you know” (Joe:RI:126).

Although the Christian doctrine of a spiritual warfare may have been the teaching emphasised in some fundamentalist and charismatic churches that some of the service users attended, or had been socialised within, most mainstream Christian institutions set no stress on a spiritual battle. For many service users it was the battle that was raging within their own minds that caused them to seek a spiritual rationalization of their experience, and to look for scriptures and religious teaching that could offer some explanation of why they were suffering so much pain. Many believed that God had suffered by sacrificing His son for mankind, and Jesus had undergone agony dying on the cross for them: “The most important thing for me about Christianity is the fact that Jesus died on the cross for our sins” Rose (RI:410). This was a God that they could
identify with because, like them, He had suffered pain. Alice compared mental anguish to physical pain which she could relate to the suffering that Jesus endured before His death.

I don't think people realise that you can actually have a mental pain. It isn't like a headache, it is just sometimes that you think you are going to explode. And it's an actual physical pain. But it's not one that I think would be in the slightest bit moved by analgesics. I can't imagine that it would, unless they put you out altogether. I can remember the actual pain and I have thought about the Garden of Gethsemane, and He was in agony. And that was mental agony, wasn't it? And I thought that that maybe my pain was, it was sort of biblical because I think that there is in the Bible sort of everything. It can fit can't it? It sort of fits with your life experience. Alice (RI:364) 45-64 years.

They could find a purpose for their torment because they could find passages in the Bible where, because of their great suffering, the righteous received a reward in the life to come, if not in this life, if they continued to be faithful to God. Many Christian scriptures pointed to life being a battle; therefore they could locate their experience of life's struggles within a framework where suffering was the norm.

Geertz (1966) saw the need for people to place their suffering within a wider context than their own lives to enable them to construct an understanding that could encompass pain and so endure it. Without this larger vision of the world the only response to their suffering would be to find it pointless and give in to annihilation. He saw religion as providing concepts that gave order and meaning to existence to counteract three types of experience that he felt could reduce the world to meaningless chaos: bafflement, suffering and evil (Geertz 1966:14). While the intellect is used primarily to find religious answers for unexplainable ‘baffling’ experiences’, ‘suffering’ necessitates an emotional religious response that accepts it as part of life. As Geertz expressed it:

With the possible exception of Christian Science, there are few if any religious traditions, ‘great’ or ‘little’, in which the proposition that life hurts is not strenuously affirmed and in some it is virtually glorified. (Geertz 1966:18)

Geertz described ‘evil’ as the third experience that threatens the concept that there is an order in existence. It is the discrepancy between moral behaviour and material rewards; the feeling that the suffering is undeserved because the sufferer has done no wrong. It is only by taking a wider religious view, such as retribution and reward in the next life, which enables people to place their experiences within a framework that sees order in an otherwise chaotic world.
It is this ‘evil’ that those who espouse a belief in the notion of a spiritual warfare see as originating from the Devil. It is the Devil who brings suffering to people who follow God as is shown in the Old Testament book of Job. This suffering is not in response to their rule breaking behaviour. On the contrary, the Devil inflicts it on the righteous, as it is his weapon against God’s followers. This was part of the narratives of some of my respondents who sought to find an explanation of their suffering of mental illness in a religious framework that explained that their pain was part of the human experience, and could be seen as proof that they were following God’s ways because, like Job, the Devil felt it was worthwhile attacking them.

Lucy (45-64 years) had not been brought up religiously at home, but was sent to a convent boarding school at the age of six with her older sister. It was a very formative experience that socialised her within a religious framework, and was no doubt instrumental in her converting to Catholicism in her late thirties at a very difficult time in her life when she was looking for answers to many existential questions. However, as an artistic six year old the imagery in the convent presented her with a strange and frightening religious world filled with women in black flowing garments with large head-dresses, and statues of Jesus with his ‘sacred heart’ on the outside of his clothes with rays emanating from it that she longed to put back into the anatomically correct position. She had instilled into her the knowledge of a spiritual battle that Christians had to engage in daily, which was reinforced by constant repetition of the Lord’s Prayer: “lead us not into temptation, but deliver us from evil”.

When she became mentally ill in her thirties, she sought for understanding of her tumultuous thoughts that threatened to throw into confusion the elements in her life that had, until then, formed her conceptual framework and provided her with ontological security: health; marriage; work; family; friendships. It was at this stage when these elements were falling apart that she looked for religious concepts to repair her shattered ‘protective cocoon’ (Giddens 1991).

However, her religious life was seen very much in terms of a battle between good and evil that had been part of her socialisation in the convent, with the good paying a heavy price for following God’s way. “I do believe in the forces for evil that want to destroy us, they want to pull us all down” (RI:44). In Geertz’s terms Lucy experienced ‘evil’ as a threat to the belief that there is an order in existence, because, although the Christian teaching was that she was loved by God, her suffering made her feel that this could not be true. Within her religious framework she found the explanation: the suffering was
caused by the Devil attacking her, never-the-less she was in fact loved by God. This understanding enabled her to endure the suffering because for her it was part of a spiritual battle that was a given ongoing state in the spiritual realm.

She felt that she was always under the Devil's attack because she had chosen to follow the Christian teaching rather than taking the world's way and values, and part of the attack was to make her suicidal. It was immaterial whether these feelings were religious or part of her mental illness, the experiences needed mediating within her framework to prevent a feeling of chaos overtaking her and leaving her no option but to commit suicide. Due to her religious framework she was able to repair the damage caused to her 'protective cocoon' by her 'evil experiences' (Geertz 1966), by using her logic and knowledge of the scriptures to see that God was still in control and her suffering was purposeful.

The logic of it is pretty persuasive. Is a loving God going to put you through this? Is a loving God going to want you to feel compelled to, you know, throw yourself into the nearest pond. And your logic says 'no, no'. A Christian who has glimpsed the lengths that the Devil will go to to destroy us can see that. He [Satan] definitely wants us dead, and if he can do it by our own hands you know, the victory is totally the Devil's. (RI:210) Lucy 45-64 years.

It is difficult for me to know what comes from the Lord. All I know is that when I am ill I want to commit suicide and that is not from the Lord. That's all I can tell you. I have to be logical and use Biblical knowledge to contradict the enemy. Saying 'no you are lying, this is not true'...Some nights even when things are going quite well, one night in five I feel so dreadful I become quite obsessed with how I would do it, what I would do, what would be the most sure way of doing it so they didn't have to rush me into hospital. Yes I do. In a very clinical often logical way... All these things go through my mind. Awful things. I wouldn't do it well because I wouldn't have my heart in it because I know that it doesn't come from the Lord...without being a Christian I would commit suicide. I think I must have done by now. Yes, I would have done by now. I don't know. The other part of me says 'would you have felt so got at, so dreadfully injured after this last breakdown to have such a protracted depression with suicidal tendencies if I hadn't been a Christian and got at by the enemy? He uses our illness...After a dreadful night of feeling absolutely awful, thinking that there is no purpose, you might as well bump yourself off...It is mental illness, but I think that the incredible thing is that you are given the faculties to fight what would possibly destroy you if you were not a Christian. Or because you are a Christian and you are attacked you can fight it. I don't know. I really don't know. I do think it is Satanic. When you are weak you can't pray or defend yourself. Your theology lets you down, because a benign God wouldn't let you suffer like this. Everything lets you down. You have got nothing when you are depressed. So it is very very difficult...I think it is
necessary to look at the whole paradoxical nature of mental illness in relation to spirituality. The Lord is a loving God and yet He lets us experience these things for what? So we are much more compassionate. So when we need to give help to other people we are far more able hopefully, because we are far more compassionate. People look at you and think 'why the hell is she alive. She should be dead. Why isn't she dead?' Because of the wonderful spirit of the Lord. The very things that we ask the Lord to take from us he says 'no, you are witnessing to me in ways you will never, never know on this planet. If you were strong you wouldn't be witnessing to me'. So paradox all the time. The thing that we hate is the thing that is saving us. The thing that we think is going to destroy us "he that loses his life will gain it". All the time paradox, paradox. If a Christian is mentally ill, life will constantly be throwing up confusion and if it is from the Lord it is pure paradox. I don't think it leads to confusion, I think it leads to saying there are certain things that are clear. He is keeping us safe because he loves us. He is working through this tremendous suffering to bring us to fulfilment of His perfect love. If we didn't suffer we couldn't have the joy. Lucy (RI: 366-380) 45-64 years.

Lucy's religious framework gave meaning to her experiences of 'bafflement', 'suffering' and 'evil'. Except when the mental illness was acute, she was able to use her framework to process her experiences and prevent her world from becoming meaningless chaos. She found a purpose in her suffering and the assurance that God could use seeming paradoxes for good; instead of seeing only confusion in her mental illness she saw God bringing "fulfilment of His perfect love". Her religious understandings and religious framework provided an explanation of suffering as part of the weapons that Satan used in the spiritual warfare to thwart God's plans. This fitted Geertz's (1966) concept, that placing suffering within a wider concept than her own life enabled Lucy to prevent her suicidal ideas overcoming her: "without being a Christian I would commit suicide. I think I must have done by now. Yes I would have done by now". She used her religion, and in particular the concept of spiritual warfare, to repair her 'protective cocoon' (Giddens 1991) that the mental illness damaged; therefore it was her religious beliefs that provided her ontological security.

7.3 The Devil

The spiritual battle was for Lucy seminal to her understanding of life, and a way she chose to express her religious worldview. However, for other respondents the Devil was not a device within their chosen religious framework that they used to account for bad events, so the explanation of a spiritual warfare did not provide them with ontological security. On the contrary, the Devil personified the terrors of their mental illness. For some they feared that they or their loved ones were possessed by him; others were
shunned because Christians believed that their mental illness was caused by the Devil. Some had been so frightened by their experiences of the supernatural and in particular demonic influences that they would not take part in the in-depth interviews. As Oliver, who originally consented to take part in a second interview explained, talking about his religious experiences would necessitate reliving the terrifying demonic visions he had endured when ill, and he became agitated just thinking about them. Agnes instantly refused to talk in depth about her religious experiences because the demonic element was too frightening.

Although the numbers were very small (n=4) it was interesting to note that all the Roman Catholics taking part in the in-depth interviews believed now, or in the past, in the devil as a personification of evil. Lucy had evidently been taught about the Devil when socialized into the faith as a child. It could be assumed that this was true of the other ‘cradle’ Catholic respondents. However, one Roman Catholic man did not believe in the Devil now, although he had done so before he had rejected Christianity when he became disillusioned with charismatic Christianity when he first became mentally ill. He now lives at home and only attends church weekly to appease his father. He associated his schizophrenic breakdown with the charismatic Christianity that was central to his early life, but before he became an atheist he believed in the Devil as his charismatic church taught a doctrine of spiritual warfare.

The other group who all believed in Satan were the three respondents who presently attended the service users’ church. However, of the five respondents who had only attended this church ‘within the last five years’, two did not believe in the Devil. It could be hypothesized that the three who still attended were least able to survive in a community church and needed the extra support they received from clergy specially trained in mental health problems, and were therefore more mentally fragile than those who had already left the church. With the fragile mental state may come a heightened fear that could be seen as appertaining to the darker side of experiences synonymous with the Devil. This tied in with the respondents who were too fearful even to speak about their religion because their mental illness was infused with frightening demonic images.

Two respondents had been taken into hospital because they feared Satan’s presence. When Ann first became ill her presenting feature was a fixation that both her children whom she adored were possessed by the Devil. “I asked my husband to take me to the vicar to be exorcised (RI:161)”, “because it was me that felt so guilty” (RI:165). It was
the vicar who was able to comprehend that her 'guilt' was in fact a symptom of mental illness and he took her to the psychiatric hospital, where after three weeks she recovered and lost her fear. However, she found the hospital terrifying because the children were brought to see her and she still believed they were possessed. She did not discuss this with any of the staff because she believed they were all plotting against her.

It was very, very frightening. Well I thought that my children were possessed and they used to come to see me and I was afraid... Because I thought that they were part of the Devil. It was a terrible thing...It was just terrifying. Everything I did was a fright. Ann (RI:191-195) 45-64 years.

Maggie too feared Satan. When she was eighteen years old she felt that the devil was pursuing her and she was admitted to the psychiatric hospital because of this.

I kept sensing death and things. The devil came after me. Maggie (RI:25) 45-64 years.

For both these women the Devil was part of their mental illness experience and was not a constituent part of their chosen religious framework. It was a belief resulting from the chaotic shattered state of their thought processes due to mental illness and as such was the opposite of ontological security.

Unlike Ann and Maggie who thought they were possessed, Julia did not believe that she, or anyone else, could be possessed by Satan. Mental illness caused Julia's world to fragment, but she did not envisage the Devil as part of this process. However, the Baptist family with whom she was living at the time of her breakdown interpreted her symptoms as demonic possession and rejected her. They belonged to a church that espoused charismatic Christianity and for them her symptoms were manifestations of the Devil and part of the spiritual warfare that they believed in. Therefore they believed that Julia was not on God's side but had been taken over by the enemy: Satan.

I've been to a Baptist Church many years ago and they were too charismatic – they were too happy clappy, well the one I went to in [town] many years ago was. And anyway when I had a breakdown I was going to the Baptist Church and they said I was evil, I was possessed by the Devil and all that kind of thing because I had a nervous breakdown. They wouldn't visit me in hospital because they said I was possessed by the Devil. Julia (RI:138) 45-64 years.

It caused her devastating confusion: not only were her thoughts racing and chaotic but they were interpreted as evil by the people she trusted, who then rejected her because of them. She had always found their 'charismatic gifts' incomprehensible and frightening, and now, when she had inexplicable experiences that needed to be mediated, she was
driven out of their home and church and committed to a mental hospital. By the time I interviewed **Julia** several years later she attended a non-charismatic Church of England service weekly and found that this form of worship did in fact give her the comfort that she had sought in Christianity from childhood.

I learnt my Christianity from School. From the age of four I was taught. It wasn't exactly a Church of England School, it wasn't known as a Church of England School, but we were brought up with Christian prayers and hymns and things like that. And from the age of four I believed. I have never stopped believing. **Julia** (RI:100) 45-64 years.

This was the religious framework that did provide ontological security for **Julia**. However the Devil was not a prominent part of it. “Prayers and hymns” offered her the positive reassuring side of Christianity that repaired her 'protective cocoon', rather than the concept of spiritual warfare that was relevant for **Lucy**.

The devil played a different role in **Fred**’s life. He had become a Christian whilst a patient in the old psychiatric hospital through listening to Christian heavy rock music. His belief in God before that time was only as “a code to live by” (RI:137). However, he had had numerous strange experiences that he believed were religious in nature, many of them involving the devil.

I got into bed and I looked up and I saw the Devil inside my jacket. (RI:54)

I thought God had sent the Devil to warn me that if I carried on the way I was carrying on I was going to hell. (RI: 60)

(When stung by a wasp) Well I think it was the Devil sending the insect world to get me. (RI: 96)

I imagined that I had lice all over my body. ... Again the Devil. The Devil trying to upset me, like the Devil does. **Fred** (RI: 106) 45-64 years.

The Christian heavy rock music evidently fulfilled **Fred**’s need of powerful and violent sensory stimulation. Not for him the notion of a ‘gentle Jesus meek and mild’; he needed a loud, dramatic expression of Christianity to be able to find a God that he could relate to. He found a religious framework into which he could fit his religious and mental illness experiences and find meaning in them. This was a form of spiritual warfare, but the battering that he believed came from Satan did not make him feel suicidal as it did **Lucy**; it appeared to add interest to his life.

And when I played the music it really made me think there really is a God and all of them experiences I had had before are all relevant to me.

182
You know. And they sing about the devil, stand up and be counted and all this sort of thing. And I think myself that they are a Church of England heavy rock band...‘Venom’ are for God. And I have been buying their things ever since. I haven't looked back. Fred (RI:144) 45-64 years.

Fred never went to a church except with the scouts as a boy, nor prayed nor read the Bible. He said that his only religious education was at school and it did not interest him. When he became a Christian his form of worshipping God was to listen to Venom’s music. His religion needed to include the Devil as so many of his experiences had involved Satan; Venom fulfilled this need as they sang about the battle between God and the Devil. “They sing about God and the Devil. All the way through”. Fred (RI:146)

Robert suffered from schizophrenia and the devil was integrated with some of his mental illness phenomena and thought processes. He had learnt about Christianity, Satan and spiritual warfare from some Christians that he met in Bulgaria where he worked briefly when he left school, and they had impressed on him how dangerous the Devil was. Although Robert feared that the Devil would hate him because he was a Christian, “I think the devil would mean a lot of harm for me in one way and another” (RI:167) and he had been taught the perils of those who succumbed to the Devil’s pleasures, he evidently thought that he was missing out on some of the gratifications in life that Satan would offer his followers. Robert’s understood that the spiritual battle that was so real to him was not part of the lives of most people, even many churchgoers, and this presented him with a conflict: he had to reject the pleasures of the Devil or he would die, while others could enjoy themselves.

I think it is a good thing that I have never tried Devil worship, because I am so perfect anyway that if I did try doing any Devil worshipping the Devil would probably do me in rather than show me some sinful happiness like sex, or sinful sex. And then cut my lifeline off in some awful way. He would play a terrible trick on me. But some people have got so little righteousness in their lives that they find the Devil quite attractive, and if that happens they tend to worship the Devil because it is good fun. But they don't realise how much trouble it can get them into. Because I am so fully fledged with Jesus and God the Devil would tear me down much quicker than most other people who do it for a lark. Robert (RI: 172) 35-44 years.

Unlike Julia, Robert did feel that Satan could inflict mental illness, and indeed had done so to him.

I think mental illness is a bit of a curse. In fact I even think it is probably
the Devil that made me ill mentally. In my opinion. (RI:245) Robert 35-44 years.

At the time that I interviewed Robert he was mentally stable, and the influence that he believed Satan had over his life was something he could face with equanimity. Within his religious framework he saw God as being more powerful than the devil, so that as long as he followed God’s way he would be protected.

Well, there could be a great battle between God and Satan but I think that Satan is outnumbered because there is Jesus as well and the angels. (RI:257) Robert 35-44 years.

The concept of a spiritual warfare helped explain some of his more frightening experiences, but because he made sure he was aligned to the winning side he had ontological security as he felt protected by God.

The respondents had differing beliefs and understanding about the Devil and the affect he had on their lives. It was only those who were acutely ill who were not able to contain Satan within their religious framework so he remained for them a frightening spectre who had power over them. For those whose illness had stabilised, they were able to use the concept of the Devil to explain their fears, but they could also use their religious beliefs in an all-powerful God to rationalise that the Devil’s power was subservient to God’s so that they were saved by God and not annihilated. In this way their religion provided a framework that helped maintain their ontological security.

7.4 God

Having looked at the side of spiritual warfare that most respondents found frightening: the Devil, it was necessary to take note of their concept of other side of the battle: God.

Only three respondents who took part in the in-depth interviews did not believe in God: William had turned to atheism from being a fervent Roman Catholic in his late teens; Sophie was a Spiritualist; and Jack vacillated between being an atheist and an agnostic.

I think I'm an atheist, I could be an agnostic. No I am an atheist but sometimes I border on an agnostic because I sometimes start to wonder if God does exist. At the moment I think that there is no God, that we just live in a godless world. Jack (RI:27) 35-44 years.

In the total sample of religious and non-religious respondents 71% (n=100) believed in God, which was nearly the same as the general population (72%, n=1484, World Value Survey G.B.). This was in contrast to twice as many respondents as the general population believing in the Devil; an interesting finding. However, in my religious
sample of thirty-six respondents that took part in the second interview 92% believed in God and 86% believed that they had been in the presence of God. It has been shown that many looked to God for protection from Satan, but other service users believed in God for different reasons.

Most saw God as a positive force that helped them, particularly in times of need. Kate felt that she was able to survive her mental illness because of her belief that God was always there to help her.

What has got me through a lot of my breakdowns is believing in God. I believed He was there, helping me. I feel God's presence in a powerful way. Kate (RI:226) 35-44 years.

Joe was also aware of God's presence with him which gave him comfort, particularly when alone.

In the past I have been on me own but I haven't felt alone you know. It is as if someone is there but I can't see him. Are you with me? The only explanation I have got for it is it has got to be God like...It's like a comforting type of feeling. Joe (RI:22-24) 26-34 years.

Morgan described God as "overwhelmingly compassionate. Very warm and radiant. A very caring personality you know" (RI:121), and God was constantly in Alice's thoughts: "I mean God is as real a presence to me, He is in everything that I do. He is in everything, He informs" (RI:248).

For these service users God was the presence that provided amongst other things company, support, compassion and guidance. He was constant and never failing unlike their lives that could be thrown into turmoil by their mental illness. He was the essential agent that they looked to to provide their ontological security.

However, a few respondents felt that they were punished by God for some misdemeanour and this was their explanation for becoming mentally ill. Ben did not want to talk about the cause of his punishment but it was evidently something that had happened at least twenty years before the interview and he felt that he was still paying the price for his sin.

I've done something wrong and God has punished me because I have been in a mental setup for twenty years. (RI:47) Ben 45-64 years.

Tom believed that he was being punished by God for making love to his girlfriend before they married, and now felt guilty because he no longer attended church. It was understandable that he created a religious framework to account for events in his life.
because he had been very religious when young having undergone a conversion experience, and he had belonged to a very evangelical church that would have taught celibacy before marriage.

Yes. I think that I should never have made love, and I should never have been that rude, and what have you. And then He (God) might not have been so nasty to me. Well, if I have a blackout I have done something that I shouldn't have done and He is punishing me for it. I was just getting my just deserts. **Tom** (RI:87) 35-44 years.

**Tom** saw a pattern to the calamities that befell him every ten years at Christmas and he attributed them to a punitive God: his father left home in 1966; his wife left him in 1977. In 1988 he lay in bed and said to God "I wonder what you are going to take away from me now, and my mother died" (RI:95). However, despite his fears nothing bad happened in 1999 and he felt that he had at last paid for his sins. In fact being able to make sense of the terrible events by incorporating them into his religious framework and viewing them as cause and effect; paying his debt to God, gave him a feeling of security. He could believe that someone was in control of his life who could call a halt to the disasters, rather than thinking they were random chaos that would never end.

**Tyler** had also attended a very evangelical charismatic church and he too felt that when he became ill it was a punishment from God for sleeping with his girlfriend. However, he criticised the church for preaching a doctrine of punishment for sin, and he felt that people with mental illness were particularly open to feeling condemned rather than comprehending the forgiving nature of God. Interestingly, although he felt that God's punishment for sins was overstressed by his church he also believed that he had been punished by God for a purpose; "He wanted to show me things. To give me compassion for other people with depression" (RI:150).

Paradoxically, although they had undergone very painful experiences it was beneficial to believe that their mental illness was due to God punishing their wrongdoing because they could see a purpose to their suffering, and it removed the terrifying alternative that no-one was in control of the world and there was no order to creation. A punitive God could be incorporated into a mental framework but an anomic world could mean annihilation.

One woman felt that her mental illness was not caused by God’s punishment, but was precipitated by the mental abuse which she received from her father until he died when she was middle-aged. In contrast to **Tom** and **Tyler** she had been taught in church that God was forgiving, and His love could help heal her past hurts:
He's a God of love. I've got to remember that. He doesn't punish. Rose (RI:409) 45-64 years.

However, due to the abuse she had received when a child she found difficulty dealing with the concept of a male Godhead. The female clergy's suggestion that she thought of God as a woman was a novel idea for her, as feminist notions had not been part of her ideology because she was in her early sixties and had grown up with very dominant males. She found the idea comforting as she had been very close to her loving mother.

Another respondent found it easier to conceptualise God as feminine. Although Jack had said that he did not believe in God during the initial interview, in the in-depth interview it became clear that he had thought a good deal about the nature and gender of God. His grandmother had been very religious and his mother had taken him to church as a child so he had a Christian notion of God. He noted that in the Bible God is perceived as male, and in art and the media He is always portrayed as a man. He reasoned that males are stronger, taller and more aggressive than females and they would not accept a woman as being superior to them, so that the concept of a female God to most men was not credible. He envisaged men as “more closely linked to the animal side of things” whereas women “have a more compassionate side” (RI:87). He saw God as a creator, and therefore this supported his understanding that God was indeed a woman.

I believe that God is a woman. I believe that if there was a God it would be a woman. Because women bring life into this world. They have babies. They are creators. It is hard to say 'which came first the chicken or the egg?' Men have something to do with the birth and that. They have a part in the birth but women do the giving and that. All the tricky bit, all the hard bit. They are the creators of life. Whereas the female egg and the male sperm and that is like a laboratory, but the women are the ones that bring forth life into this world. So I would think that anything creative is female. Jack (RI:81) 35-44 years.

It appeared that both Rose and Jack found relating to a woman less intimidating than to a man, and when forming their image of a transcendent being this preference was transferred onto their notion of God. For Rose this was a conscious decision in response to the clergy suggestion, but for Jack it reflected his insightful analysis of relationships, roles and gender characteristics. In fact both were looking for a compassionate God and in Jack's view this was a feminine attribute. It was interesting to note that despite declaring that he did not believe in God, Jack was the respondent who had thought most about an entity he did not accept existed.
A few respondents thought that they were God or Jesus when in an acute phase of their illness. Hugh had believed that he was Jesus when very ill in the old psychiatric hospital, although he knew now that he was not.

I thought that I was Jesus. And I have found out since that a lot of people with mental illness have had that experience. They have thought that they are Jesus. Hugh (RI:30) 35-44 years.

He had reasoned with himself that he could not be Jesus because he was not ‘special’ enough to speak with ‘the Father’, the angels, and the whole universe as he felt that Jesus would be able to do. However, he wanted to talk to me about his friend who still had a fixation that he was Jesus, and became violent when anyone tried to reason with him that this was a symptom of mental illness rather than a religious truth. [Name] was one service user that the psychiatrist did not want me to interview for fear of stirring up his religious delusions so it was interesting to hear how Hugh related to him. Hugh tried to take [name] to church to enable him to see a wider religious viewpoint but he resisted. Hugh learnt to avoid discussing religion and had to be careful not to mention the name of Jesus in [name’s] company because he was not willing to collude with his friend’s delusion that he was ‘the Father’s son’.

Another respondent who had religious delusions when ill was Julia. When she was hospitalised during a manic phase of her illness she had believed that not only did she have God’s power within her, which could be seen as a normal religious notion, but she also believed that she was that power, i.e. she was God. Like Hugh she reasoned with herself that this was not so because she did not feel powerful when well. She found it very embarrassing remembering how strange her thoughts had been when acutely mentally ill.

Well it is very hard to talk about, really, because it makes me like I am totally mad if I start talking about things like this. Julia (RI:80) 45-64 years.

Although it is true that some service users believe that they are part of the Christian godhead when ill, it is unusual for the belief to be an ongoing state as with Hugh’s friend. The fact that it is a stereotypical image of a mad person makes service users very tentative about talking about their thoughts when suffering such delusions, and they do not want to recollect them when they are well.

The image and purpose of God took several forms which reflected the different needs and experiences of the service users. An important formative factor that moulded their
visualization of God was the socialization and teaching that they received throughout their lives and within the church they attended. Those that frequented fundamentalist or charismatic churches were more likely to envisage a punitive God than those who attended churches that paid less attention to biblical teaching and were more concerned with ritual.

7.5 Experiences of Church Attendance
As has been noted, teaching within a church helps to inform the religious viewpoint of the adherents. Only two service users who took part in the in-depth interviews stated in the initial interview schedule that they did not attend, nor had ever attended, a church for anything more than the rites of passage services: baptism, marriage, and funerals. However, in the second interviews it transpired that both these men had been involved in a church in their youth: Ben had been sent to Sunday School; and Matt had spent time as a child in a convent orphanage because his mother was ill, and he had continued attending a Roman Catholic Church with his parents when he returned home. Also, both men were in their early sixties and would have received instruction in Christianity at school. Therefore, all the respondents had had Christian doctrine taught to them at some stage in their lives and inevitably Christian notions would have been incorporated into their spiritual and cultural framework, although many reject this socialization.

However, when looking to see if religion is a factor that the service users look to to provide their ontological security, the religious practice that had been chosen by the individual was more apposite than that absorbed through early socialization, that may become irrelevant in adult life. William's case shows that early religious beliefs can be rejected for any number of reasons, and even church attendance does not conclusively indicate that the person chooses to base his mental framework on Christian ideology. Although William's happiest years were when he was in a charismatic Christian group at school and attending a Roman Catholic Church with his family, his severe schizophrenic breakdown caused him to reject Christianity and become an avowed atheist whilst still continuing to attend church weekly with his father since returning home to live with his parents. At one time religion definitely provided William's ontological security but not anymore. He now looked to worldly provision for his self-identity and security rather than to God.

Church attendance proved to be a painful experience for some respondents. It has been shown that some service users, in accord with the teachings of their church, felt that
their illness was caused by God in retribution for sins committed, and one respondent was even rejected as being devil possessed because her church viewed mental illness in that light. However, other respondents had felt rejected because of their sexual orientation that did not accord with the biblical teaching professed by the church. Yet others felt stigmatised and unwelcome because they suffered with mental health problems. In fact when analysing the in-depth interviews very few respondents felt comfortable within a church, despite fifteen (42%) attending a service at least once a month.

Two women attended their local Church of England parish church once a week and felt accepted by the congregation and had their needs met by the church. Sharon still attended the same church that she had always gone to with her mother, but they now had two services with very different styles of worship to cater for dissimilar congregations.

Well we are sort of in two congregations. I am in the older congregation that has been there a long time. We are sort of traditional. And then the other is more modern and can be a bit ‘clappy-happy’, because far more of them are younger. And they tend to dominate...Ours is at 9 and theirs is at 10.30. Sharon (RI: 109) 45-64 years.

She did not like happy-clappy services, but found comfort and reassurance in the familiarity of the ‘traditional’ services:

I'm not ‘happy-clappy’, definitely not ‘happy-clappy’. I don't like it. And I don't think it is doing much good (RI: 119)...I feel secure and safe with the people I know and things I know and the services are nearly always the same. Sharon (RI: 129) 45-64 years.

While a patient in the old psychiatric hospital in the 1960s Sharon had always attended the hospital church. It was Sharon who had encouraged Val to go to church while they were patients in hospital together because she liked singing in the choir. Since Val had settled in her sheltered accommodation in the community she, like Sharon, attended her local parish church when a church worker gave her transport. She would have liked to have been more involved with the church and remain after the service to get to know people, but accepted that the lady who drove her did not want to stay and that no member of staff would drive her. The important factor for Sharon, and no doubt for Val, was the format of the service. Unlike the fundamentalist churches that preached biblical doctrines that caused upset to many respondents, their traditional churches conducted services that were low key and familiar, that instilled a feeling of continuity and security. They did not want to be ‘challenged’ by the preaching or excited by loud
or modern music; they needed reassurance that their religious life was stable and secure unlike their experience of mental illness. It was this stability that enabled them to find ontological security within their faith.

The service users' church also held traditional Church of England services, with the added benefit of having clergy who were trained to help their congregation interface their religious and mental illness experiences. This gave added stability and security to three respondents: Hugh, Rose and Kevin.

However, some respondents benefited from non-traditional services. Walter found his local Church of England service charismatic and the congregation very welcoming. When his mother died shortly after he came out of the psychiatric hospital he became deeply depressed and was introduced to the curate of his local church by his sister-in-law. Through the curate he became a Christian and then lived with him and his family, and when they left he found a flat-mate and an employer within the congregation. The church fulfilled not only his spiritual needs but helped with his temporal ones too, which gave him a feeling of security. For a man whose life had been shattered by mental illness then the loss of his mother and father, the 'Christian family' within the church became fundamental to his ability to 'carry on' (Giddens 1991). Sadly with a change of clergy the atmosphere within the church changed and he no longer felt welcome.

Unfortunately, the present vicar is a bit of a disappointment. He is a bit radical, he has made a lot of changes and a lot of people have left the church...The whole atmosphere is different. I feel less welcome there...This makes it harder for me to keep going. Walter (RI:121-125) 45-64 years.

In fact this church was mentioned by several respondents as having once been a church where they felt welcomed and cared for but since the change in clergy the whole ethos of the church had changed. Kate felt that people with mental health problems had a particular need to feel accepted to dispel any fears of being stigmatised:

Well I go to church to find my strength really...Churches need to make people with mental illness feel accepted and welcome. To show them that society is not against them. A lot of mentally ill just haven't got the confidence to even go round the shops let alone church. But um sometimes with these churches I get the impression that they are very middle class and snobby sometimes. My church is now too snobby. Kate (RI:183-186) 35-44 years.

Luke had also attended this church since childhood and like Walter lamented the
change that came with a new vicar and his curates. Instead of being accepted and helped he felt unwanted and stigmatised, because a new emphasis was placed on wealth instead of the more spiritual virtues that he associated with Christianity and the church.

I think this is now a building of sinners. They are fake Christians. They are not real. I have very negative thoughts on the church at the moment (RI:110). When I have seen the clergymen and the vicar at St [name], the new ones, I've looked at them and I have thought 'you are only in for it for the money', 'you are fake'. And I don't believe that they have a true ministry. Because my mind is telling me that they are just there for a living (RI:144). The impressions they give is 'I'm not really interested'. And you do feel 'why do I bother'? But I'm talking about one particular community church. Which at one time, prior to a certain vicar who came the Revd [name], was wonderful. Prior to his arrival, with Canon [name] who was there before, when he led the church everyone was such a community. And when he left and retired and Revd. [name] came it became a commercialised type of industry. Everything seemed so businesslike. It was not as warm or as friendly. People who you thought you could talk to, you couldn't talk to. If you saw someone that you knew from the church they wouldn't speak to you. One person completely turned off years of friendly warm fellowship, which is what Christianity is about. Luke (RI:249) 35-44 years.

It was not the style of worship that had upset the respondents, nor indeed any harsh biblical scriptures; it was simply a lack of care for vulnerable people who looked to a Christian church for love and acceptance as they had learned that this was a principle tenet of Christianity.

Another respondent who looked for a non-traditional church because "I find that I am more comfortable with that sort of worship" (RI:25) was Grace. She had tried several churches and found that although initially she felt welcomed, she soon started feeling estranged and needed to leave.

I very soon get that feeling of being odd and isolated in that group. And sometime I really feel quite threatened and won't go back to that church. Grace (RI:25) 45-64 years.

She felt that it was not acceptable within churches to be honest about having a mental illness which was against all her Christian understandings; she believed that this was the one place where people should be able to be open and honest about their problems without being rejected. However she was made to feel that: "You should keep quiet about it. You should be able to wear a mask when you come to church and pretend that everything is alright" (RI:31).

It was sad to note how few respondents found that attending a church brought them
much comfort, and indeed most felt unwelcome in a church congregation. They did not complain about issues of doctrine or church politics that more powerful church goers discuss; theirs was a simple need of acceptance and being made welcome.

It was hard to see that attending church actually helped many of the service users find comfort and security in their religion, but as several commented 'you don’t need to go to church to worship God'. They found God outside the church and many prayed alone or with friends, and some studied the Bible to find a Christianity that helped them in their lives.

7.6 Prayer

Many respondents (75%) stated in the Interview schedule that they prayed or meditated ‘often’ or ‘sometimes’. Bible study was only spoken about within the in-depth interviews if it was relevant to the respondent, but it was often linked in their narratives with prayer.

Prayer was a practice that could be performed alone or in company with others, but it was the private prayer that was particularly significant for many respondents because this gave them some control, or perceived control, over their lives. When afraid, lonely or confused they could communicate with a higher being to help, protect or guide them. The public prayer was more grounded however, in that it was a validated cultural religious practice acknowledged by others who were not suffering from variable thought processes brought about by mental illness.

Prayer for Alice was central to her life and the technique she employed for managing the disruptions caused to her by her manic-depressive illness. She belonged to a prayer group within her church which contained the core set of friends who “affirmed and bolstered” (RI:106) her through her marriage break-up and illness. However, there were also those who she felt said they prayed for her but then deemed that they had a right to direct and criticise her. She was helped to pray by a course run within this group on different methods of praying.

We tried different methods of prayer; putting God somewhere and seeing what happened. Just watching Him. And I knew when I did that He just came closer and closer and closer until it was inside me. You know I’ve always remembered that sort of sensation. There was one about doing a picture, imagining a picture. I can remember that I was a bird, a huge bird, black feathers, lots and lots of black feathers. And this person came up and put out a hand and just picked off all the black feathers, and underneath were a whole lot of white feathers. I quite liked that one. All
sorts of different ways we were taught. And the church had taught me that so when I became ill, even though there were bad experiences, and even though people didn't understand, I had been taught how to survive. Alice (RI:364) 45-64 years.

And I have prayed about things and a way has come whenever I have. Not in the sense of asking for something, just I don't know what I'm going to do, I just don't know. Sitting there quietly and you get up and you go away and, um, some way is introduced into your mind. Alice (RI:360) 45-64 years.

In fact it was not the church in her adult life that imbued Alice with the practice of praying. She described herself as having been "a very religious little girl" (RI:272), and remembered having a prayer life with formal sets of prayers from the age of seven. This was understandable as her grandmother, mother and aunt were high Church of England and "did their bits" (RI:274), which entailed "reading the office every morning and every evening" (RI:274). Her father was not included in their religious practice because he was considered a "heathen", which worried Alice until she found out that in fact he was a Christian but "very low church". When she was aged three, living in Calcutta during the Second World War, she had gone to light candles in the cathedral to pray for the armed forces. As she commented, the uncertainly and fear engendered by war turned people to seek God.

Oh yes and there was a little children's corner where they had candles lit for the soldiers, sailors and airmen. So I was forever lasting dashing in there to pray for the soldiers, sailors and airmen. Quite genuinely pray for them, I mean I would do it when I went to the park and when I went away, you know. My poor ayah standing outside waiting for me. But I think when you live in wartime you are a lot closer to God. Alice (RI:282) 45-64 years.

Throughout her life therefore, she had learnt that there was an immanent power that was omnipresent and concerned about her welfare. This person, God, could be communicated with in good times and bad, and He would never desert her. She was not alone in this belief, but was reinforced by others who affirmed the benefits of praying. This was important for someone whose thoughts could not be trusted to be an accurate representation of reality because they varied with her state of mind; manic or depressed. Alice used prayer to repair her damaged ‘protective cocoon’, and it was to her deeply held religious beliefs that she looked for help to survive the onslaught of her mental illness. Without God and her ability to communicate with Him she would have been consumed by a feeling of ‘chaos’ as her life appeared to implode with mishaps and mental illness. It was her religious beliefs that provided her ontological security.
One woman who suffered with “racing thoughts” (RI:108) and hearing voices had been helped by her husband who taught her to pray for herself when symptoms of her mental illness started intruding into her mind. “I did have faint voices about ten days ago I think, and I got rather rattled. But I thought I must turn to prayer” (Megan RI:110).

Rose found that prayer, both personal and having people pray for her in the service users’ church, was the essential element that helped her overcome her fears and enabled her to ‘carry on’. To encourage herself when she was feeling low she recalled the answers to prayers that she had already received in order to “lift her spirits” (RI:520).

One very isolated woman spent much of her time talking to God to ask Him to protect her and all the people that were precious to her. In fact she also prayed for her current budgies, and even other animals and birds that were dead but which she believed to be with God in heaven. Unlike Alice, Ann had not been brought up in a religious family, although she had been sent to two convent schools and had excelled in the religious instruction she received there every day. While there she learnt to appreciate prayer: “I used to go very quietly away sometimes and go to their chapel and pray” (RI:129). Like Alice therefore she had an early religious socialisation that provided her with techniques to her endure her mental illness and isolation.

Being a devout Roman Catholic Lucy not only prayed to God for protection but also to the Virgin Mary. She was concerned that her prayers should not be seen as mere superstition as they provided her with the sense of security that was vital to her existence and prevented her from committing suicide.

I would pray. I would say 'dear Lord this is disquieting, this is upsetting. I need to bring this to Our Lady. I require the protection of someone who said that she is concerned with our day-to-day well-being. She doesn't want to see us destroyed; she doesn't want me to commit suicide. I know you are prepared to help as well but Our Lady has promised us this sort of, you know the constant vigilance and help to those who love you'. But it's always those who love the Son, it's never any suggestion that I worship Our Lady that is just, just anathema and superstition. Lucy (RI:86) 45-64 years.

Another respondent, John, was also concerned that his praying should not be seen as superstition. He had a set routine of prayer and Bible study each morning before leaving for work and felt that if he did not have a “quiet time” (RI:393) his day would not go well. However, he rationalised that even if it was a superstition it was a good one.

Kevin had experienced the healing power of prayer when the clergyman prayed for him whilst in the psychiatric hospital and subsequently he started looking to God for help.
When in the community he would telephone or visit the clergy to pray for him to try and enclose and neutralize his suicidal thoughts. It was the words of the prayers and hymns that he used to counteract his painful thoughts, and he had a book of prayers that he read to quieten his mind.

I've got a little prayer book...there's just nice words, not even mentioning Jesus they're nice words and I feel safe, you know, and you're going to be all right. It's like its saying 'you're going to be all right', um, 'be strong' and all that. It gives you, it gives you, I think it gives you a lift ...it gives you a lift the next day, it gives you strength. Kevin (RI:126) 45-64 years.

As prayer had been for Alice so it was for all these respondents: a beneficial means of controlling their anxieties and a means of repairing their 'protective cocoons'. However, prayer for Ryan was confused with symptoms of his mental illness because he believed that people could listen to his private conversation with God and they would prevent God answering his supplications. “And then whatever you pray, if it is something that you want to happen and God wants to happen it might not happen because they have heard it” (RI:76). For him religion did not provide ontological security because it was part of his mental illness process and did not give him comfort or protection.

One man who suffered from schizophrenia turned to praying after he heard Jimmy Saville say “if there was nobody to talk to there is always God to talk to” Robert (RI:37). In his loneliness Robert took it literally and communicated with God as if He were in control of all life, and could influence those around him to make them treat him well and release him from hospital. He needed to believe in a supremacy who would mediate for him, who was more powerful that those who ruled his life within the hospital. However, in Robert's mindset God was not omnipresent, and it was necessary for him to relate to God what was happening in his life: it was almost as if he had to make a mental image of the people around him and by telepathy transmit their images to God so that God would know whom Robert was talking about when praying. Being settled in the community Robert continued his practice of reporting to God people who upset him, and he also continued a prayer practice that he had found efficacious when in the old psychiatric hospital: praying on the ground floor. In his flat he always knelt down “in the very bottom of the building” as he believed that “it's harder to get in touch with the Holy Spirit upstairs than downstairs” (RI:83).

Also, another thing I do is I always make sure that I am on the ground, or on the foundation of the building because I think if you say a prayer upstairs it goes to the Devil, which I learnt on [name of locked ward in old psychiatric hospital]. I found out that if I went downstairs and prayed
actually in the corridor or floor there was more chance of getting in touch with Jesus or God than on an upper floor. Strangely enough because the foundation or the floor is more secure than upstairs in a building usually.

Robert (RI:77) 35-44 years.

He had fashioned this pattern by trial and error, finding that he “had better luck” (RI:79) when praying on the ground floor. He also remembered his Christian friends in Bulgaria remarking that the Pope kissed the ground when alighting from a plane, so he formulated the theory that it must have a spiritual significance.

Robert’s life was constantly being thrown into chaos by his mental illness and his religious practices were one system he utilised to find stability and a purpose to his suffering.

Prayer was as natural a part of life for Tyler as talking with his temporal friends. Attending a charismatic church he had undergone the ‘Baptism of the Holy Spirit’ and practised ‘glossolalia’, although when he first heard people within the church ‘speaking in tongues’ he was disturbed and thought, “This is weird, they’re a bunch of nutters” (RI:128). However, one day while he was alone driving his van and praying he found himself very briefly ‘speaking in tongues’, and then he believed that his friends were sane and the experience was real.

I was just talking and all of a sudden I started praying in tongues. Now I didn't know what it was at the time. It only lasted about thirty seconds. This thing came out of my mouth and I am thinking. I stopped because I was thinking ‘what was that?’ Now it didn't happen again for two months. It took me two months to realise what it actually was and I went ‘Oh tongues are real, they weren't making it up and it wasn't satanic’. So basically I felt God used that to convince me 'look Tyler, they're not making it up, I'm real mate'. I feel I am very blessed the way it happened because no one else was present. It says in the Bible that it's for believers and unbelievers. Now I didn't believe it and I was a Christian yet it still happened to me, so that's quite good. Tyler (RI:128) 26-34 years.

Prayer took many forms in the respondents’ lives; from reading set prayers from a book to practising glossolalia. Whatever style it took, prayer not only created bedrock on which they created their religious framework but it also filled in cracks that appeared in their ‘protective cocoons’. It could be used in many different forms: to protect; instruct; reassure; guide; and provide companionship. It was an essential element that held together the service users’ lives and prevented them being annihilated by their mental illness.
7.7 Conclusions

The literature had noted, and my research confirmed, that people with enduring mental health problems showed higher religious interests and needs than the general population. By looking at their religious beliefs and practices I have sought in this chapter to evaluate whether their religious understandings had enabled them to create a framework that provided them with ontological security.

One man, who interestingly described himself as an atheist, summarized what he thought were the benefits of religion.

Well once people think that there is someone looking after them they feel their problems seem to dissolve. Sometimes a problem without a God seems really big, but when there is a God it is like he helps you get through the problem. Praying is a bit like meditation, it's where you take your mind off things. You concentrate all your powers of thought into one. You can sort of verbalise it. You can hear yourself talking in your prayer. You are not actually talking but you can almost hear the words that you are thinking. That helps to relax you. It is good if there is a God that can hear your prayers. It helps you to feel better if there is a God. The more people that believe there is a God the better it is. You are talking millions of people. Maybe billions of people believe in God so people think it has to be true because so many people believe it. Then once they have got that established in their head that there is a God, when they pray to God it makes them feel really good about themselves or they feel happier. I used to pray when I was younger. Yeh it did, it made me feel better. I used to pray at night. Jack (RI: 105) 35-44 years

Analysis of the respondents' narratives supports Jack's understanding of the reasons why religion benefits people who believe religious, in this case Christian, doctrine to be true. They can find someone, God, who cares for them and who will help them overcome all difficulties. If this God is also powerful and omnipotent He can overcome any opposition. Communicating through prayer can be relaxing and bestow a feeling of wellbeing. If it can be shown that 'billions of people' share the same beliefs it can belie any fears that it is simply part of your own mental construct, which may be faulty due to mental illness.

Mental illness can throw into confusion 'givens' in life that give a feeling of permanence and continuity. Looking to Christian doctrine and scriptures gave many respondents an explanation for their painful experiences that enabled them to see a purpose in their suffering. As Geertz noted, embedding their distress in a wider context enabled them to view their misfortunes as being part of human existence. Indeed in spiritual terms it is the 'proposition that life hurts' that is acknowledged in most religions as normal, and indeed even beneficial, gave them the understanding that there
could be gain in their misfortunes. Therefore, despite feeling rejected and stigmatised by people because of their mental illness they could look forward to greater rewards from God than those who had never suffered such hardships.

For many of the respondents their religious beliefs did provide a basis for constructing a religious framework that could find explanations for their confusions and distress. They were able to use their beliefs to find a way of rebuilding their sense of security in an uncertain and ever changing world. They did indeed use their religious beliefs and practices to find ontological security.
Chapter 8
Talking and Telling

8.1 Introduction

In Chapter 7 I argued that to regain and sustain their sense of ontological security; their sense of continuity and order in life, the service users looked to religious beliefs and practices. However, in many cases this entailed the social process of discussing this area of their lives with others. I now turn to this process.

In the framework of the adult world, the caretakers who created the ontological security in the child are replaced by different agents who help maintain the service users’ ability to prevent ‘chaos’, the opposite state of ontological security (Giddens 1991), from overwhelming them. In the case of the long term mentally ill these agents are not only family and friends but also members of the medical profession. For some service users who are religious, professional and lay agents within their religion may be called upon to help re-establish the “protective cocoon” (Giddens 1991:3) that enables people to cope with day-to-day living, which may be damaged by the mental illness.

In the adult Giddens sees language as a means of mediating human experience; the human ability to communicate thoughts and feelings in a fluid-time span. He quotes Lévi-Strauss’ notion that language is:

...a time machine, which permits the re-enactment of social practices across the generations, while also making possible the differentiation of past, the present and future. (Giddens 1991:23)

In this chapter I want to explore the ways in which the service users made use of agents, if indeed they did, to restore their ontological security by using language to evaluate their religious lives with the medical professionals, clergy, other service users, friends and family.

The narratives from the thirty-six in-depth interviews will be analysed to investigate those who used language in ‘talking and telling’ others of their experiences of suffering with enduring mental health problems and looking to religion to answer their existential questions.
8.2 Customary and Extraordinary Communication

Communication, and in particular listening to service users, is central to this research project that attempts to identify the viewpoint of a group of people who have been marginalised by society. Many were excluded from society and spent years in the old psychiatric hospital, and even now most are not fully integrated into the community despite living within it. They have been ‘talked to’ and ‘talked about’ by the many people who control their lives, the professionals and in some cases their carers, but their narratives are seldom heard. Most research into the field of mental illness has been undertaken by the medical professionals and academics for their own professional audiences, and looks at issues that are relevant to their worldview and requirements. As Foskett argues: “Currently, psychiatry has control of research as much as it does of care and treatment” (2004a:2). There is a need therefore to reverse the focus of concern and listen to the voices of the service users, who, as end users of the diagnoses and treatments prescribed by the professionals and society, have different needs and priorities. The medical professionals are often concerned simply with the presenting mental state, and may never look to the issues of ontological security that can become confused by a fluctuating self-identity caused by mental illness. Sadly, Giddens’ statement that to be human is to have self-knowledge and awareness “virtually all of the time” cannot be said to be true for many service users:

...to be a human being is to know, virtually all of the time, in terms of some description or other, both what one is doing and why one is doing it. (Giddens 1991:35)

When suffering an acute episode of mental illness, particularly of a psychotic nature, their sense of identity, surroundings, interactions with other people, and discernment of time and space can be thrown into confusion by hallucinations, delusions and misperceptions.

Until the last few years little heed was taken of the religious interests and needs of people suffering from mental illness (Foskett 2001; Larson, et al. 1986; Needleman and King 1993); in fact patients’ views on any subject were of little consequence within the long-stay psychiatric hospital system. However, the work of McKerrow and Faulkner (1997) highlighted the religious needs of over 50% of her sample of long term mentally ill people, and in this current research 67% had had a ‘religious experience’ and 60% described themselves as ‘religious’. Despite this evidence of interest in spiritual matters the mentally ill have not been given a forum to speak about this area of their lives, and
have in fact been reticent to divulge their personal feelings in this area. As Macmin and Foskett point out:

For the last century, service users have been, if not afraid, very ambivalent about telling their story and especially their religious or spiritual stories. (Macmin and Foskett 2004:23)

To gain an understanding into the significance that religion holds in this group of people this apprehension of ‘talking’ about their religious lives and ‘telling’ of their experiences needs to be overcome. However, if Hay and Nye’s (1998) finding that children as young as six are apprehensive about revealing their spirituality for fear of being regarded as ‘strange’ and even ‘mad’, it is understandable that those so labelled should hesitate from divulging their innermost thoughts, thus reinforcing this interpretation of their religious ideas as ‘madness’. To do so may further damage their ontological security by inferring that their understandings of the world are merely worthless delusions.

Communication is the exchange of ideas, thoughts, feelings, or knowledge from one being to another. I use the term ‘being’ in this context because the communication for religious people may be with a spiritual being rather than a human being, and in the case of people suffering with mental illness the recipient of the communication may be their own hallucinatory entities.

Although communication is often thought of as a verbal exchange, other mediums are frequently used to convey an inner feeling: facial expressions such as a smile, frown, tears or stare may express deep emotions; body language such as a shrug, slumped posture, an averted gaze, crossed arms or fidgeting hands may reveal more of the person’s thought process than the words used; and non-linguistic sounds such as sighs, groans, snorts or laughter may be used in place of words to convey meaning. During the in-depth recorded interviews body language, sounds and facial expressions were frequently used particularly when reliving painful experiences and recounting deep personal feelings. The sounds were recorded on the tape and some body language was recorded in the field notes.

Usually at least two individuals are involved in communication; one informing and another receiving the disclosure, each taking turns. However, when looking at the communication process involved with mentally ill religious people the picture is much more complex than that of two people engaged in a conversation. Mentally ill people may experience auditory or visual hallucinations and enter into a dialogue with their
voices. They may engage in several dialogues concurrently: with the real person in front of them and with any number of others in their hallucinatory worlds. It is often very difficult for sufferers to distinguish between the experiences they are engaged in and those experienced by the rest of the world. The complexity deepens when it has to be taken into account that the dialogue can be viewed as a sign of mental illness by the medical professionals whereas a religious person may interpret it as a spiritual revelation.

In the religious context, the person may be communicating with a being not visible to anyone. To other religious believers the concept of communicating with unseen spiritual entities is a normative practice within their understanding, which they would classify as praying to, or worshiping, 'God'. However, to a non-believing stranger from another culture the notion of 'praying to God' may be as irrational and outside normative behaviour as talking to hallucinatory people.

Within this framework therefore I see two categories of communication:

**Customary communication** – talking to other substantive humans.

**Extraordinary communication** – talking to hallucinatory beings, or praying to spiritual entities aloud or within the mind.

For ‘customary’ verbal communication to take place a culturally bound set of rituals is enacted, sometimes without either player being aware that they are being performed. Cues are given out by both parties that demonstrate their willingness to interact with each other, and while communication is in progress more cues are given that may reveal encouragement or disapproval of the content of the conversation, discomfiture, or a desire to terminate the exchange. These cues, which may be verbal, facial or body language, may guide the course of the conversation and affect what information is disclosed. Factors such as the status and power balance of the communicators will influence the conversation: a service user’s speech when answering a doctor’s questions will have a very different format, style and flow than when chatting with a friend. I feel that this power differential may be key to the reason that Hay’s children (Hay and Nye 1998; Macmin and Foskett 2004)) and Macmin and Foskett’s service users (Macmin and Foskett 2004) feared revealing their spirituality: they were subordinate to the investigator. The cues given by the more powerful person dominate the exchange, and the only defence that weaker parties may have to guard their ‘protective cocoon’ is to keep silent or end the conversation expeditiously.
These concerns were illustrated by Joe who expressed his unease at having to speak with the psychiatrist and preferred to keep the conversations as short as possible. He had spoken about religious matters but simply as a mutual topic of conversation not because he wanted to confide in her. He had seen her in church and therefore assumed that they shared a similar religious understanding.

I do talk to Dr [name] because she is a Christian herself...I have seen her in church. I do have a chat to her about it from time to time...Well I don't know if it helps but it is something to talk about when you have to see the doctor, because I always feel a bit nervous when you have to go and see the doctor, you know...I let her do the talking really. I just answer her questions and open my mouth when it is appropriate sort of thing. You know. (RI:152-158) Joe 26-34 years

'Extraordinary communication' is a different genre to ‘customary communication’ in that no other human agent is involved, and the service user does not have to be subservient to another human being or be aware of the other’s cues and agendas. However, this is not to say that the service user is necessarily in control of the communication in the conventional sense. Hallucinatory beings may appear to the service user to be powerfully in control of the interaction.

Tyler, for example, described an incident that happened to him while he was alone driving a van in the course of his work. He was thinking about the relationship he had with his girlfriend when he believed that God spoke to him. For him it was no different to having a conversation with a human friend but he felt that God was in control of the verbal exchange, although he was aware that he had initiated the topic.

And I was sort of thinking 'do I love her?'. 'should I be going out with her and sleeping with her?', which I knew was wrong but it's difficult sometimes. And, er, I was actually driving, because I used to do a lot of driving for the company I used to be with. And I was sort of half praying to God and it's ongoing like talking to a friend, basically talking to Him like He was standing next to you sort of thing. And I know who it was now, but at the time I didn't know who it was. What it was, I was praying and this voice sort of comes into my head and challenged me basically and said, 'You don't love her', because I was doubting about going out with her.

Did you actually hear the sound?
Yes.
Were you surprised at that?
No, I wasn't.
Had you ever experienced anything like that before?
No, and never since really, not like that. What happened then was this voice started saying, because I was praying about it. I think I was actually having a conversation with God saying "Look Lord I do love
her" but felt that the Lord was saying "no, you don't". This wasn't really audible but all of a sudden when I was praying about it this voice said, "No, you don't love her". And I was a little taken aback and went "Oh", and frowned a bit and just carried on talking to this voice. And this voice started having a go at me... It was basically saying "you don't love her". I kept saying "yes I do". And the voice kept repeating "you don't love her" and I said "yes I do". And in the end I got so fed up with it that I said "why not, why don't I love her?" and this voice just said "well you did this, you got this person to take the morning after pill and that's really selfish". And at that, that was it and I didn't think anything more about it. Obviously I felt a bit guilty. I was about twenty-three I suppose...I felt a bit guilty about it and that evening I went home and saw my girlfriend and it was an apology, but it wasn't a real apology, and I sort of said to her that I felt guilty because the voice having a go at me. I felt a bit guilty and thought I had better make it up to her. I'd better apologise sort of thing. I didn't tell her about the voice or anything. (RI:32-40) Tyler 36-45 years

The importance difference in these two forms of communication, 'customary' and 'extraordinary', is the way they are interpreted by the medical professionals and other agents. Joe's views were taken at face value as normal cultural religious beliefs, whereas Tyler's conversation with God was pathologised by the doctors as symptomatic of schizophrenia – "the doctors thought that I was schizophrenic. Yeah. I know they did" (RI:406). For Tyler his conversation was a discussion of existential questions with a 'friend' – 'am I behaving badly?', a way of processing his Christian moral principles, whereas the doctors saw it as a first rank symptom of schizophrenia: hearing voices. This was very damaging to Tyler's ontological security in that it denied the viability of his belief system, and damaged his self-identity as a normal functioning person.

His reaction was to regret speaking of his religious experience.

In some ways I wished I'd kept me mouth shut at the time, when I said that because of repercussions. Yes I wished I never said anything because of repercussions. (RI:326) Tyler 36-45 years

The repercussions of his telling the doctors about what was in his view a 'religious experience' was to be stigmatised by being diagnosed as suffering from schizophrenia and admitted into the mental health system – "people aren't going to take you seriously, because you are schizophrenic. It's the stigma" (RI:382). He found that even his friends within his church treated him differently.
The next three sections will look at the communications that the respondents exchanged with other people about their religious life interfaced with their mental illness, and the reasons why some chose not to speak about this area of their lives. Sections 8.3 and 8.4 will assess why the service users did not speak about their religious lives, and section 8.5 will look at those that felt confident enough to discuss religion and who they discussed it with.

8.3 Fears of Religious Ideation Being Pathologised

Clearly Tyler regretted talking about his conversation with God to the medical professionals, but other respondents had different reasons why they did not discuss their religious lives. For some the religious experience was so long ago that it bore no relevance to their present lives and therefore they had no wish to discuss that element of their lives with the present psychiatrists. However, for others the interfacing of their religious lives and their mental illness was an ongoing process.

If, as has been argued, the respondents were using religious beliefs and practices to restore or maintain their ontological security it would follow that before discussing their religious lives with a particular agent they would question, albeit usually subconsciously, whether that person would fulfil the role of helping them in this quest. Secondarily they would have to ask the existential question “can I trust this person?” In normal day-to-day living from earliest times this has always been an ongoing question of survival and would be answered using judgements of life experience. However, mental illness can make answering both these questions difficult because thoughts and life experiences become confused.

For many people, when they become acutely mentally ill the only agents they are involved with are the medical professionals and other service users, i.e. strangers. They lose contact initially, and sometimes permanently, with their families, friends and religious contacts. They would therefore need to assess if they could trust their innermost thoughts to such people.

Several factors have to be taken into account here: the onset of the illness, acute or gradual; the seriousness and invasiveness of the illness; the nature of the illness and whether the users had insight into the fact that they were acting out of character with their habitual selves, or that their worldview had come into conflict with that of others. The point being, that different illnesses, or even different stages of the illness, would affect the service users’ decision whether or not to speak of their religious life to
another person. **Tyler**'s state of mind at the time when he was admitted into the psychiatric service, whether due to schizophrenia or not, was such that he was totally pre-occupied with the experience of his conversation with God in the van and was therefore unable to prevent himself from discussing it. By the time I spoke to him several years later he was able to decide whether or not to talk about his religious life and experiences.

**Tyler** was not the only service user who felt that his religious views were interpreted as signs of mental illness and pathologised. Several respondents had implied that they were concerned that if they spoke about religious matters when diagnosed as suffering from a mental illness it would be dismissed as part of their mental state. Their religious experiences would not be validated by psychiatrists as real happenings but viewed simply as a pathological symptom of their illness, and they would be prescribed medication rather than being talked to about their religious lives.

Conversely, one respondent was not perturbed by his religious experience being pathologised. Seven years before the interview **Angus** had a crucifix tattooed on his right arm because he heard Jesus say to him,

'I'll leave you alone if you have the tattoo done. And I won't talk to you any more.' (RI:116) **Angus** 18-25 years

As with **Tyler**, the psychiatrist did not discuss any religious ideas with him but simply prescribed medication. However, unlike **Tyler** this did not damage his ontological security because it appeared that his religious belief system was not the element that provided his 'protective cocoon'. He was happy to agree with the doctor that this religious experience was simply a symptom of his mental illness and that taking medication would enable him to stop hearing the voice of Jesus speaking to him.

He didn't really say much, he just said 'I'll increase your medication'. It didn't upset me. Well I hadn't seen many doctors before that and so I just thought maybe that is the reaction of a doctor. (RI:158) **Angus** 18-25 years

It was interesting to note that in the initial interview, a year before the recorded interview, **Angus** had given a slightly different account when describing his religious experience. Instead of being required to have a tattoo done 'to stop Jesus talking to him', previously he interpreted the command as a 'proof of his belief in Jesus'. He said:

When I was ill I thought that I heard Jesus telling me to get a tattoo done to prove that I believed in Him. (IS) **Angus** 18-25 years

207
Angus had been brought up in a Roman Catholic family but in adulthood he had rejected his parents’ religious teachings; hence the internal religious conflict that was evident in the two versions of the content of the voice that told him to have a crucifix tattooed on his right arm. He said that he ceased attending church when he left home “because my parents stopped forcing me to go” (IS). He described his religious status as ‘don’t know’ and said that he was no longer interested in religion. Evidently when ill he was unable to process his present religious views and they became entangled with his religious upbringing. For him now God was not important (‘5’); therefore when the doctors rejected religious notions as a dominant worldview they did not denigrate his self-image because he was in agreement with them on this issue.

Angus had no striving to be discharged from the mental health system and said that he had friends within the system but none outside it. Again this was dissimilar to Tyler whose friends were mainly outside the system, and he fought against having a label of schizophrenia which might keep him within the mental health system. It was possible that the mental health service helped provide Angus with his ‘protective cocoon’, in contrast to religion providing Tyler’s ontological security.

It appeared that the important factor that governed whether service users would be damaged by an agent pathologising their religious experiences was the level of commitment they invested in their belief system.

Five other respondents held firm religious beliefs: two were Spiritualists and three were Christians.

Sophie was a Spiritualist, as was her mother before her, and she said that it was to a medium or someone from the Spiritualist Church that she would go for help with a spiritual matter. She felt that if she told the psychiatrist about her religious experiences they would be conflated with the symptoms of her mental illness and they would be pathologised.

If I told this to Dr [name] she would probably think I am nuts, just because I believe in Spiritualism and that sort of thing. (RI: 155) Sophie 35-44 years

Sophie would have liked to have been able to talk about her religious life with her psychiatrist because “just speaking about it might give some sort of peace” (RI:327), but she believed that the doctor was too busy to spend enough time listening while she explained what was normative for a Spiritualist. Just as Tyler had found when speaking about his religious beliefs to someone who did not understand Christian doctrine,
Sophie felt that communicating with someone not versed in Spiritualist beliefs would be difficult and destructive to her understanding of whom she was in the context of a Spiritualist worldview, thus causing damage to her self-esteem.

Likewise Morgan was a Spiritualist and had had many religious experiences that would be outside the cultural norm, but normative within Spiritualism. He described some:

I have seen ghosts before. I have seen spirits. I saw my Nanny, the top half of my Nanny, hovering through the dormitory. Also I have seen a light, a shining light that blinked out in half a second. (RI:40). Morgan 26-34 years

He had talked to doctors about his religious ideas, particularly when ill when his beliefs were more pronounced. At such times he saw himself, familiar people and animals as biblical characters.

I do think I am Jesus sometimes. Well just because I look a bit like Him. The moustache and things. I know I'm not really; He's up above in Heaven. In Heaven above looking down on His creation. (RI: 164)...I tend to think that people around me are religious figures sometimes, you know. I think Mum is Judas Iscariot, and things like that (RI: 180). ...Well Smudge my cat is Tutan Kamun, a false prophet, (slight nervous laugh), and John the Baptist as well. (RI: 186)...Well I see David [surname of service user] as King David, but I have my doubt about that, that he is King David really. Well he is a bit too presumptive and a bit too um cantankerous really (slight nervous laugh). He is a bit too filthy to be King David. King David is more holier. I must admit that one I am definite about, I know that my friends Pete and John they are the apostles Peter and John. I'm sure about that. I just know they are. I think that Phil Collins is Philip, the apostle Philip. And Simon and Garfunkle, Simon is the apostle Simon. And Garfunkle is Bartholomew. And Nathan [surname of service user] is Nathaniel. And James [surname of service user], Jimmy [surname of service user] is James. And Andrew [surname of service user] he is the apostle Andrew. (RI:210) Morgan 26-34 years

There appeared to be two levels of spiritual experiences that Morgan was constantly analysing and toying with: one that belonged to his Spiritualist belief system and the other that he recognised was part of his mental illness. “I don't know. It's just that, it's just a religious mania that I've got. Religious mania, a bit” (RI:184).

Although he was able to differentiate between the two forms of experience because he understood the Spiritualist worldview, the doctors only saw one and pathologised all his religious experiences. This was very damaging to his ontological security because in dismissing all such experiences as delusional it dismissed the part that was fundamental to his understanding of the world, one which he shared with his mother. She was instrumental in shaping his ontological security as she was his primary nurturing agent.
and he had not rejected her worldview when he grew into adulthood. Like Tyler, when he was well he wished he had not spoken to the doctors about his religious ideas because they pathologised his experience and prescribed more medication.

I have talked to the doctors, yeah. I used to but I try to keep hush, hush now, because they just put me on more and more tablets if I tell them and I'll be on more injections. I am trying to deal with it in my own way really. (RI:282) Morgan 26-34 years

Both Lucy and Julia were committed Christians who attended church once a week and both feared that their Christian beliefs would be seen as part of their mental illness.

No, I would not discuss any of my religious experiences with a doctor because I think they would just put it down to illness. (RI:277) Julia 45-64 years.

I think it would be seen to be another dimension of my illness. In fact I am sure that mentally I would feel the doctor saying 'paranoia, ah, schizophrenia, hearing voices you know. Thinks she's talking to God'. (RI:220) Lucy 45-64 years

Neither woman wanted their deep Christian belief systems belittled by doctors who dismissed their religious notions as mere delusions which they interpreted as part of a mental illness. In the turmoil of their illness, with all the concomitant confusing thought processes, the one sure foundation - or to use a Christian simile a ‘solid rock’, which they could depend on was their Christian faith. Their Christian beliefs repaired the breaches in their ‘protective cocoons’ caused by the mental illness. To interfere with their ‘solid rock’ would be to damage their cocoons, which in turn would be to annihilate the inner self.

Seen from a Christian perspective, the very understanding of a ‘rock’ as a solid foundation to life is in itself a Christian concept that both would recognise. Jesus renamed the apostle Simon ‘Peter’, ‘a rock’, when He declared, “You are Peter, a stone; and on this rock I will build my church; and all the powers of hell shall not prevail against you.” (Matthew 16:18). The context of this declaration would also not be lost on these women. Jesus had just asked his disciples who ‘people’ thought that he was, to which they replied, John the Baptist, Elijah, Jeremiah or one of the other prophets. He then asked them who ‘they’ thought that He was and Simon answered, “The Christ, the Messiah, the Son of the living God” (Matthew 16:16). Jesus is delighted that his disciple understood His true nature and rewarded Simon’s perspicacity by making him the founding father of the Christian Church: Peter.
“God has blessed you, Simon, son of Jonah,” Jesus said, “for my Father in heaven has personally revealed this to you – this is not from any human source. You are Peter, a stone; and on this rock I will build my church; and all the powers of hell shall not prevail against it. And I will give you the keys of the Kingdom of Heaven; whatever doors you lock on earth shall be locked in heaven; and whatever doors you open on earth shall be open in heaven!” (Matthew 16:17-19)

The whole essence of Christianity, and most other religious belief systems, is the recognition and understanding of hidden truths. It is the nature of religious beliefs that spiritual revelations are often withheld from many of the general population, particularly the worldly wise and powerful, and only revealed to a few that can understand the mystery. In the eyes of my religious respondents most psychiatrists would come under the category of the ‘worldly wise and powerful’, who would not recognise the hidden mysteries that had been revealed to them. In reality many acknowledged that it is often difficult to comprehend fully what is knowledge that the “Father in heaven” (Matthew 16:17) has revealed, and what are their inner confused thoughts. It is to be able to confirm the former and discard the latter that communication with another person is helpful. However, the other person requires an understanding of the tenets of the faith to be able to act as a counsellor.

Both Lucy and Julia were educated and articulate and were able to explain what communication would be helpful for them when trying to interface their mental illness with their religious beliefs. Julia wanted to be able to talk at length when she was ill to try and make sense of her confused and often frightening thoughts, and Lucy wanted someone who would have the same religious worldview.

Lucy was a very devout Roman Catholic who attended church once a week, but she had not spoken to a doctor about her religious life. Satan was very real to her and she was constantly aware that she lived in a spiritual battle waged between good and evil: God and Satan. She felt that being a Christian made her mental illness worse because Satan was trying to destroy her.

Well I think the Lord can use our illness and can make us better people through suffering. So you can't say that without going on to say the enemy, him downstairs, he is going to be equally active when you are ill to try and, you know, intimate to you that the Lord doesn't really love you, that He's not concerned about you, that He wouldn't let you suffer like this if He cared about you. You know, you might as well, you know, give in. I mean suicide and all those things do come to your mind at times like this. (Ri:210) Lucy 45-64 years

However she also described the joy of the victory she sometimes felt as a Christian who
was loved by God.

When the loving God shows you that He loves you the joy is just so real that it is just as real as the despair is when you are down. So I would say it is a heightening of both. It is a heightening of the wonder and the goodness and the joy. As I say joy is, it's a word which you have got to add vibration to because it is so much more intensified. It doesn't match ordinary prosaic happiness. It is a feeling of not even euphoria, because that is a state that isn't real. It is a real joy. It's based on things that you know are true when you are feeling well. (RI:214) Lucy 45-64 years

Within those two quotes Lucy incorporates many of the concepts of the Christian faith which she, and other respondents, espouse, some of which are contained within Jesus' words to Simon Peter above:

1. The fact that there is an unseen spiritual realm: heaven and hell.
2. Within those two realms are forces for good and evil.
3. There is a conflict between these two forces.
4. That conflict has an effect on people on earth, particularly Christians.
5. God is all-loving, and encapsulates all good experiences.
6. Satan ("him downstairs" - Lucy) wants to destroy God's creation and in particular Christians.

Within this worldview Lucy examined all her experiences, but without this understanding of Christianity her florid description of the highs and lows of her mental illness is very confusing. She is looking for confirmation that the frightening thought processes when ill can be explained within a firm understanding that there is a sure foundation of spiritual knowledge, a 'rock' that she can trust, and that she is still loved by God despite the ravages of her mental illness. In fact there is a purpose to her suffering: she is so loved by God that Satan will fight against her with more determination than he would someone who was not a Christian. Her Christian faith is essential to provide a protective cocoon within which the mental illness can be contained and explained. Without this cocoon lies annihilation: "You know, you might as well, you know, give in. I mean suicide and all those things do come to your mind at times like this."

Her beliefs and feelings were so embedded within the Christian religion that she did not want to discuss them with medical professionals who might destroy her 'rock'.

It would not be appropriate. Not really. I think that you have an inkling that it is somewhat embarrassing, you know, to someone who isn't a believer. Um, and I know that, it could be, it could be also not politically
correct, I mean it could be insensitive to discuss it with someone who was not of your tradition. (RI:216) Lucy 45-64 years

Although Lucy would not tell the doctors about her religious life there was one person that she spent many hours a day talking to: God - by herself or in the company of other Christians. She was concerned that a psychiatrist who was not versed in the Christian concept of ‘praying to God’ might interpret this religious practice as a symptom of her mental illness. In the non-religious context, speaking with non-existent entities is a sign of a delusional state. Therefore, for Lucy prayer was her lifeline to sanity because it confirmed her ontological security, but to a doctor she feared that it would be the opposite: proof of her insanity.

I think it would be seen to be another dimension of my illness. In fact, I am sure that mentally I would feel the doctor saying 'paranoia, ah, schizophrenia, hearing voices you know. Thinks she's talking to God, ah huh'. You know all these mental notes. I'm sure the doctor would have to employ his training into interpreting what I was saying in a way that I would find quite difficult to take. (RI:220) Lucy 45-64 years

Lucy and Rachel felt that they would not feel confident speaking to a doctor who did not share their Christian beliefs. However, unlike Lucy, Rachel was neither highly articulate nor well educated, and it took a while to tease out whom she would be comfortable discussing her religious life with, and why.

She had changed from being treated by a white woman psychiatrist to a male Indian psychiatrist, so she had before her two very different people demographically and could examine her feelings towards each. She realised that when she was being treated for her mental illness, rather than engaging in a social situation, a different set of criteria became operational when deciding whether to talk about religious matters. In the clinical situation she felt very vulnerable, and therefore would not divulge her inner religious thoughts to anyone whom she felt might ridicule her feelings about God; “Him upstairs” (RI:59).

I think I'd feel, even though I don't think he would mind, I'd feel like I was raw. Being exposed...He might not take it seriously. Yes and laugh. You'd feel let down again. (RI:391-393) Rachel 45-64 years

She felt that she was wary of all ethnic minority doctors because she could not work out what their religious ideology would be, although she was not against them per se. She then compared two white women doctors and realised that she felt happy with one because she thought that she was a Christian, but felt the same about the other one as she did about the ethnic minority man. It was, therefore, neither their gender nor
ethnicity that concerned her but their religious worldview.

I think I would feel vulnerable. I don't know. I think it’s because I wouldn't want her to sort of catch me sort of undressed. For a want of a better word. (RI:453) Rachel 45-64 years

**Rachel**’s protective cocoon, which she saw as being provided tangibly by “Him upstairs”, was the only element that had kept her from feeling overwhelmed by her life experiences. It was understandable therefore that she would guard her inner religious knowledge from ‘worldly wise and powerful’ people who could use their learning to pierce her cocoon, and let in doubts that God was not ever present to protect her.

In fact both women were expressing their fear of the unknown. Their religious beliefs were central to both their lives, and both kept them from anyone who might confuse their religious feelings with their mental state thereby desecrating something that was very precious to them. Their lives were filled with the pain of mental illness and they did not want damaged the little part of them that brought comfort and hope; their Christian belief in a loving all-powerful God. It was important therefore to be confident that speaking about their spiritual lives within the clinical context was with someone who understood their religious worldview and would respect it.

**Grace** had found it helpful talking to me but was wary of talking to a psychiatrist about her religious feelings. She lived alone and described herself as ‘religious’, but did not attend a church so was isolated from anyone with whom she could talk about her religious life. She identified herself as belonging to a distinct group of stigmatised people, the mentally ill, “people like us”. This in itself showed how fragile was her self-image.

Well I feel that it has helped get things off my chest. It is good to talk about it. I feel it is very good to talk about how we feel, people like us feel in relation to our religion. I don't think that I would talk to a psychiatrist. I think that I fear that people will misinterpret spiritual experiences. (RI:277) Grace 45-64 years

Part of her reluctance to disclosing her religious thoughts was that she was not always sure what was her mental illness and what was a religious experience. Speaking to a psychiatrist who did not understand where her beliefs originated from, and who might pathologise an element she considered was spiritual, was a risk she dared not take.

Quite frankly it is jolly difficult to know when you are having a spiritual experience. It could well be that you think that you are having a spiritual experience and it actually isn't... Well I suppose that if you think that you have been shown something by the Lord. I wouldn't want a
psychiatrist to say "oh well, this is another manifestation", and it could be. I'm not saying that they might not be right. I think that I would find it very hard to be told that some of the things that I found most helpful in life were just aberrations. Because I think one is spoken to deep within. One does have a deep voice within that sometimes speaks to you, and you have got to answer to that if you want to be a Christian. I think that a medical person would not understand my experiences. If they weren't Christians they would think that it was very, very strange to have them. (RI:283-287) Grace 45-64 years

Pathologising religious experiences that mentally ill people interpret as within their religious belief system is very damaging to their ontological security, and can harm their self-esteem and identity. Some noted that they may need help in distinguishing which experiences were religious in nature and which were indeed symptomatic of mental illness, but religious service users did not trust psychiatrists to be able to fulfil this role. In fact the literature would support this view: doctors and psychologists are less religious than people with mental health problems (Kroll and Sheehan 1989; Needleman and King 1993); they are less religious than the general population (Kuyck, et al. 2000); medical professionals do not take into account the spiritual lives or concerns of their patients when treating them (Foskett 2001; Larson and Larson 1991); and there is a 'religiosity gap' between the medical professionals and their patients (Lukoff, et al. 1992).

The medical professionals would seem therefore not to be in a position to act as agents that could help religious service users differentiate between experiences which are induced by symptoms of mental illness and those that could fit within a culturally normative religious framework; they would pathologise them all. In fact, it is probable that they would consider such differentiation to fall outside their role as doctors. If Needleman and King (1993) are correct, many psychiatrists would argue that it would not benefit their patients to encourage any religious ideation. If this is the case, it is understandable that service users are reluctant to speak about their religious lives. However, this leaves the religious service users in a very vulnerable position, because the powerful professionals who control their lives when ill are unable and unwilling to help restore their 'protective cocoons' that have been damaged by illness.

Giddens proposes that the 'basic trust' which has been established from infancy provides a "sense of invulnerability" (Giddens 1991:40) to the possibility of harmful events overpowering an individual, thus underpinning their ontological security. However, I would argue that the reverse might take place: the ontological security could be damaged due to mental illness overwhelming the individual, thus removing the
‘sense of invulnerability’, which in turn damages the individual’s basis trust. This can be a frequently occurring event but normally it is only temporary, and the individual’s ‘protective cocoon’ is soon repaired when the frightening event proves not to be overwhelming, and the feeling of relative invulnerability is re-established. It is only when the thought processes in mental illness cannot re-establish habitual feelings of security that an agent is needed to help restore their basic trust and repair their ‘protective cocoons’. The care given by the initial nurturing agent that established the ‘basic trust’ is probably no longer available, and the care is now given by medical professionals who may not see the need to attend to ontological security. The service users have to look elsewhere for repair to their basic trust and ‘protective cocoons’ and some look directly to religious beliefs and practices.

8.4 Religious Ideology: A Private Matter
Religion was not an issue that the medical staff raised with the respondents, and was only talked about if the service users brought it into the conversation. Evan was a Jehovah’s Witness who talked about religion on all possible occasions, although he had been forbidden to proselytise at the sheltered workshop because this upset the other workers. Other respondents had spoken about their religious ideas when it was a preoccupying feature of their mental state, particularly in the acute stage of their illness. As has been noted, both Tyler and Morgan mentioned their religious voices, but when less acutely ill, they regretted having done so.

However, most of the respondents chose not to talk about their religious notions because they deemed it a private matter, and the staff avoided talking to them about spiritual topics possibly for the same reason; religion was a private matter for both groups. This may have been a reflection on English society in general, where “don’t discuss religion and politics” is a familiar injunction to prevent arguments. Certainly the annoyance caused by Evan’s proselytising was spoken of by several respondents, and one service user explained that he was concerned that he might be attacked because of it.

Evan at [sheltered workshop], he has been told lots of times before and the staff told him today “enough is enough about Jehovah’s Witnesses”. He is on about the Watchtower and everything. He brought two Watchtowers in and, you know. I have got to be honest, it gets me a little bit down, but I hate to think it that one day someone might, you know, land him one. (RI:121) Sam 45-64 years

Foskett (2001:406) pointed to another potential reason why religion was avoided in the
clinical sphere. While some medical staff will dismiss all religious experience as pathological, there is in fact much confusion amongst medical staff about the interface between religion and mental illness in service users’ lives. Since religion can either cause harm or be beneficial, and they do not themselves understand the issues involved, they tend to avoid the subject or let the service user take the initiative in speaking about it. However, if this was a concern amongst medical staff, it was not one of which my respondents were aware. They looked to their own problems and needs, not to those of the people who treated them.

The main reason that the respondents chose not to talk and tell and decided to keep their religious lives private was fear of the consequences if they disclosed their thoughts. Tyler and Morgan were proof of the astuteness of this decision. As Rachel explained, disclosing your inner thoughts to another person is like feeling naked in public: “I wouldn't want her to sort of catch me sort of undressed” (RI:453). It exposes sensitive areas to the outsider’s gaze, not of the physical body but of the psyche, putting the service user in a very vulnerable position. A fragile self-image could be annihilated by the gazer pouring scorn on the individual’s worldview and interpretation of experiences. Very often thoughts and feelings are not analysed but are absorbed into the subconscious and accepted as part of the ontological security; the way of understanding the world and finding safety within a threatening environment. There is a need to protect this inner self, this personalized ‘framework of reality’ (Giddens 1991), and preserve the integrity of the personal decision-making processes, even if sometimes mental illness alters the reality. However, this is not necessarily a well-defended area and can easily be disturbed by a deprecating word from a doctor, with damaging consequences. This creates a situation in which the respondents are not willing to bring to medical attention confusing experiences which could well benefit from being discussed with someone with a knowledge of the illness process, who should be able to help the respondent identify what is illness and what is their own thoughts. It led to Morgan saying, “I am trying to deal with it in my own way really” (RI:282).

Kate said that she had not discussed religion because the doctors were too busy. However when I asked her if she would speak about it if given the time, she realised that she did not want to open up this part of her life to the medical staff.

I just want it to be a private affair with me, really. When I go to see a psychiatrist I go to talk about my illness. (RI: 212) Kate 35-44 years

I asked her if she had ever discussed her religious ideas with the present consultant
psychiatrist and she replied quietly but very determinedly:

Oh! no, no. Nor with [psychologist]... Well um. I don't want them to delve into that side of things really. (RI: 215-218) Kate 35-44 years

She explained that when she was very ill she had experiences that she thought were spiritual but now believed they were part of her illness. She found the whole area confusing and frightening and preferred not to think about it. She decided therefore to keep her religious ideas as a private domain so that she had control over whether they should be analysed and talked about. If a doctor knew her thoughts on this matter they could be challenged, and she feared that her feelings of being 'gifted' rather than 'mad' might be ridiculed.

All I know, I would like to say this. I don't really want to confuse my manic illness with being spiritual because I believe now those visions or those dreams I was having was part of nightmares or the drugs, because the drugs can make you have these dreams sometimes, they can...I thought they were spiritual. And because I thought they were spiritual this is why I didn't open up to some of the people in hospital. It was my illness but I thought it was a gift I had, and I was frightened of it, I was. I was frightened... But now I look back in retrospect I realise quite honestly it was part of my illness really. Because I am not spiritual. I believe in Jesus in a Christian way, but I don't want to delve into spiritual life at all really...I didn't want to talk about it because I didn't trust anybody, that's why. Well I felt very frightened and vulnerable in these wards in hospital really. (RI: 238-244) Kate 35-44 years

For my religious respondents many of the elements that provided explanations for the confusion of their mental illness were to be found within a Christian framework. As Lucy expressed, Christianity can give a purpose to suffering: “Well I think the Lord can use our illness and can make us better people through suffering” (RI:210). Whilst such ideas are in tune with Christian theology, they are arguably in contradiction to humanist Western philosophy. As has been shown, religion turns scientific empirical concepts upside-down. For example: ‘good can come out of evil’; ‘the weak and unlearned are strong and wise in religious understandings’; ‘although poor and lacking in worldly possessions you can be rich in the spiritual realm’. However, if, as Goffman (1963) argued, being mentally ill identifies you as a ‘stigmatised’ person with a ‘spoilt identity’, the world may consider that all of your thought processes are damaged. Therefore you are not in a strong position to make the ‘powerful and strong’ (i.e. those without religious understanding) believe that your worldview, as opposed to their secular understanding, may be valid. In fact, only those in a very deluded state would attempt to proclaim as ‘real’ their controversial views, such as “I do think I am Jesus
sometimes" Morgan (RI:164), against the normative cultural ones. However, most people with mental health problems when not acutely ill are in no way different to anyone else; they have their own views on life but are aware that they might be wrong. Nevertheless, they are in a much weaker position than others to defend their understandings, and can only protect their psyche by keeping their thoughts, particularly religious ones, from the gaze of others.

Several of the respondents stated that were not willing to subject their worldview to the examination of the medical professionals and preferred to keep their religious notions in the safety of their private lives.

Sophie had a particular reason for keeping her religious ideas private. As has been mentioned, she was a Spiritualist and had had many spiritual manifestations that she felt people would confuse with her mental illness. Unlike Kate who confused the two areas herself, Sophie knew the difference but feared that others would not.

I tend to keep things private because people are not, eh, especially if you have a sort of mental health illness people think it is that aspect of you causing the problem. Whereas I have always been interested in spiritualism and that sort of thing, psychic experiences... I think you have to sort of be careful who you talk to about things. I think it is private really. (RI: 155, 161) Sophie 35-44 years

As has been already argued, people who hold beliefs outside the cultural norm are even more open to scepticism than religious people who hold the middle ground. Although Christianity, unlike Spiritualism, is the religion that most English have some knowledge of, those at the extremes of Christianity also have to defend their thinking. Not even nominal Christians would understand or share charismatic Christian beliefs let alone people of other religions or none, which would be true of most medical professionals (Kroll and Sheehan 1989; Needleman and King 1993).

Sarah had undergone a charismatic Christian religious experience and although she no longer went to church she did still ‘pray in tongues’. She felt that people would not understand the charismatic gifts of the Holy Spirit so did not discuss her religious life, and particularly avoided revealing her religious thoughts to the medical staff.

I don’t really talk about my religious views much... I don’t think they would understand them really (RI:328). Sarah 26-34 years

Conversely Val had not talked to doctors about her religious beliefs for another reason, despite them being fundamental to her life. She was brought up in a Christian home and still attended church once a week. While in the old psychiatric hospital she had been
instrumental in bringing other patients to a Christian faith and encouraged them to attend the church there. However, she considered her faith and her mental illness to be two parts of her life that had no bearing on each other.

No. I don't discuss my religion with Dr [psychiatrist]. Well it's none of her business. I just discuss my illness with her. Just my illness. The two don't mix up. They don't go together, do they? They don't mix. (RI:209)

Val 35-44 years

Although Val had suffered the negative effects of mental illness for many years she appeared to have a good self-image and a healthy 'protective cocoon'. As Giddens points out, everyone develops a "framework of ontological security of some sort" (1991:44) as they mature from infancy and this reflects the ability of the nurturing agents to enable the child to 'go on' (Giddens 1991) in the face of harmful experiences in the social life, secure that chaos will not overcome them. Evidently Val had created a 'framework of sorts' and her Christian faith was incorporated into her ontological security from early childhood and stayed with her as a given through her life. When her illness threw her thought processes into confusion at times; a state of 'chaos', which for less ontologically secure people would have been catastrophic, Val was able to ' bracket out' (Giddens 1991) these experiences and maintain a healthy self-esteem. She was free to choose to 'tell and talk' or to keep silent, because, despite her illness, she had an inner security.

Most of the respondents who undertook the in-depth interviews were in the age bracket of 45-64 years and many had lost touch with their families through death, distance or estrangement. However, in the younger age groups many still saw their families although they did not discuss religious issues with them: Richard (26-34 years) said his parents were not interested in his religious views and would not discuss them with him; Angus (18-25 years) never told his mother that he had been tattooed in response to a voice telling to have a crucifix put onto his right arm; Morgan (26-34 years) had discussed his religious ideas with his mother but was told, "Oh stop going on." (laughs) (RI:280); and Robert (35-44 years) had talked to his parents but they were not interested in his religious notions.

"I'm afraid that holds little water with me", my Mum said. And Dad said, "If you want to believe in it you can believe in it but I don't personally believe in it". (RI:299) Robert 34-45 years

The decision not to tell and talk was made for a variety of reasons, but mainly for fear that the consequences of discussing their inner lives might be detrimental to their
ontological security, because external agents dismissed them merely as mentally ill people with faulty thought processes.

Next it is necessary to analyse the respondents who did speak of their religious lives, and to whom.

8.5 Confident Religious Service Users

There were few respondents who discussed their religious life and mental illness, and those that did spoke in the main with clerical professionals: Anglican clergy, Roman Catholic priests and a Salvation Army Captain. Only six service users discussed their problems with people in the congregation: two attended the service users’ church, one a charismatic Free Church, two a charismatic Church of England, and one a Baptist Church.

However, respondents who belonged to a church group were more likely to be able to make friends outside the mental health service. As has been noted some were more tolerant of mental illness than other secular organisations; however these tended to be the more charismatic Christian Churches who were more open to ideas that were outside the secular cultural norms. Depending on your viewpoint, mental illness could be seen as an exaggerated form of some of the ‘Spiritual Gifts’ such as ‘listening to God’, ‘having visions’, ‘receiving words of knowledge’ or ‘speaking in tongues’, or indeed the reverse: ‘Spiritual Gifts’ are an exaggerated form of mental illness. People who shared the concept that there is a realm other than an empirical one might be less hasty in diagnosing ‘hearing a voice’ as a symptom of schizophrenia.

Joe sometimes discussed the interface between his mental illness and his religious faith with people in the Baptist church but he felt that they had a very negative view of mental illness; it was demonic, so he tried “not to mention it”:

I do talk to people in church, but they don't really er, (pause). They ain't got much time for it really. They don't understand at all I don't think, not really. They just think it is demons or whatever I think...I find it better not to mention it, you know, when I go to church if I can help it. You know, I would rather just not mention it. These people have got problems of their own anyway. They don't need me rabbiting on about my problems, you know. It's no help to them really, you know. (RI:146-148)

Joe 26-34 years

In contrast to this Tyler had always been able to talk at length to his charismatic Free Church Christian friends, and said in the initial interview that what he found most
helpful was “people praying for me and listening, particularly one friend who was a very good listener”. The difference between Joe’s and Tyler’s experience of being able to discuss their problems within a Christian context may be due to their personalities, the different beliefs of their churches, or the age composition of the congregations: Tyler (23-34 years) was loquacious and had many friends his age with whom he could relate in his church, whereas Joe’s was reticent and the Baptists were either young teenagers or “people who were sort of in their forties and up to retiring and pensioners and that sort of age” (RI:102). Walter and Alice both belonged to different charismatic Church of England congregations and although they were older, 45-64 years, they had friends of their own age in the congregation to whom they could talk. Walter found that friends in his charismatic Bible study group were ‘most helpful’ (RI:212), and Alice’s praying friends helped her through her depression.

Rose and Hugh had no difficulty talking with their congregation because the focus of the church was to provide support for people with mental health problems and the clergy were trained for this. Two factors therefore point to the receptivity of a congregation: the way mental illness is understood within the church, and/or finding people in a similar age group to befriend. If the teaching of the church is that mental illness is concomitant with demon possession, it makes it dangerous to talk about being mentally ill because to do so is to admit to being taken over by the enemy of the Christian Church: Satan. In no way would this help the self-image or repair breaches in the ‘protective cocoon’ caused by the mental illness, so Joe was wise “not to mention” his mental illness within his church.

The other factor; comparability of age, probably made communication easier because there was less of a power differential than when speaking to older people, and there would be a shared knowledge of growing up in the same era. However, speaking to the clergy may have benefits not found in the congregation: greater knowledge of the doctrine of the church to help provide the ‘rock’ of a sure foundation, giving a reference point against which to help measure their experience of mental illness.

There were two types of clergy that the respondents had spoken to about their mental health problems in conjunction with their spiritual lives: those who were employed by the National Health Service who had knowledge of mental illness, and those who were in the community who may have had no training in the mental health field. Research (Fellowes 1996; Foskett 2004) shows that community clergy and pastors have scant training in the mental health field. This may be a reason why some service users found
sanctuary in their dedicated church where the clergy could help disentangle religious experiences from mental illness generated experiences: they became important agents in restoring the ontological security.

Within the old psychiatric hospital there was a full time Anglican clergyman who was available for all the patients, who visited the wards and held services in the hospital church. Outside priests, other denominational clergy, and other religious leaders would visit the hospital when required. All the respondents who had been in the old psychiatric hospital and mentioned speaking to clergy about their mental illness had talked to the hospital clergy, mostly when they visited the wards but a few had attended the hospital church services. Since closure of the hospital the same clergy run the service-users' church and provide clerical counselling in the community. However, many of those who spoke to clergy while in the hospital have no connection with the community clergy service and no longer speak to any religious leaders. The respondents who had spoken to community clergy tended to be those who had never been in the old psychiatric hospital.

Hugh was a patient in the old hospital and had spoken to the clergyman within the hospital when he visited the wards, but Hugh did not attend the hospital church. After the hospital closure he continued to receive help from the clergy and now attends the service users’ church. He received encouragement from the clergy to speak in the church about his religious experiences, which gave him a religious, as opposed to an illness, interpretation of his ‘visions’, which affirmed his self-identity and reinforced the feeling of God providing him with ontological security. He did not talk to the medical staff about his visions for fear that they would dismiss them as a physical phenomenon caused by his cataracts. For Hugh they were a special sign from God that He was with him through the suffering of not only his mental illness but also the problems that he had with his sight. Whether or not the visions were caused by the cataracts was immaterial. It was the interpretation that Hugh gave them that was crucial to his ability, to use Giddens’ term (1991), ‘to go on’. To believe that God had sent them as a sign of His presence gave Hugh a sense of peace, so that he welcomed the visions rather than fearing them as heralds of another mental breakdown.

I have spoken about my visions to [clergyman] and the group meeting that we have. I’ve spoken to people at the prayer meeting and church. I’ve told people actually out loud what happened. If you weren’t religious you would think ‘oh this man is going mad’. What’s the matter with him, sort of thing, unless you have experienced it or you have heard about it or you believe in that sort of thing. I don’t talk to my CPN. Not really. I
don’t know why. It is mainly to [clergyman] I talk. He encourages me to talk about my faith in the church. Well it renews my strength in the spirit sometimes because that was the whole idea. It reoccurs and lifts my spirit again. You know what I mean? (RI:95) **Hugh** 35-44 years

**Walter** had also talked to the clergyman when he visited the wards because he was a Christian, but like **Hugh** he did not attend the church services. He needed the encouragement because he found it difficult to maintain his Christian practices when mentally ill.

Another respondent who had spoken to the clergy when in the old hospital and now attends the service users’ church was **Rose**. She had returned to church after many years absence and was frequently talking with the clergy about her painful memories of her father’s abuse. When she spoke about her need to forgive him as part of her duty as a Christian to the medical staff, they encouraged her to speak to the clergy. They felt that Christian forgiveness was a spiritual matter rather than one that they could treat with medication and cognitive therapy.

My [psychologist] told me that I must talk to [clergyman] or [clergywoman] and they might be able to help me. I’ve got to forgive my father. Well I think I should as a Christian do that. I’ve, I’ve got to forgive him. I know he’s ruined my life, and he’s made it very difficult for me at times but I still feel that being a Christian I **must** forgive him. That is part of what I’ve got to do. And I think, then, maybe I might never have the nightmares again. I spoke in depth with [clergyman] about this. You know we were talking about it in the car coming home one time. We had a chat for about twenty minutes. (RI:21) **Rose** 45-64 years

This was the only case where the medical staff made reference to any religious bodies and encouraged a service user to seek help from the clergy. The abuse that **Rose** suffered from her father, who was a primary nurturing agent, had impeded the growth of a healthy ‘protective cocoon’, which negatively affected the whole of her life. She looked to her Christian faith to repair the damage that he had done and believed that with spiritual healing she would be cured of her nightmares.

The hospital clergyman played a different role in **Ann’s** life. She became paranoid and believed that her children were possessed by the devil, but when she called the police they simply told her husband she was disturbed and left her. It was the clergyman who talked with her and took her to the hospital.

So I talked to [clergyman]. He didn’t say anything other than that he wanted me to go into [hospital] as a patient. (RI:181) **Ann** 45-64 years
Grace had spoken to a priest when she first became ill and found the help he offered very significant. She had spoken to no one else and he had listened to her viewpoint and connected with her needs. He had made time for her to communicate her feelings, and in her depressed state this tangible proof of another’s care reinforced her feelings of self-worth.

I think just being kind, being loving, giving time to you when you know that they are busy, that says a lot. That is practical. That is saying I'll make the time for you, even though I have got other things I could be doing. He deemed it important enough and I am grateful to this day for that, because people say a lot more by what they do than by what they say. (RI:51) Grace 45-64 years

Although the experiences of different service users varied, the main theme that ran through their narratives was the need to have the clergy listen to them and treat them as they would any other member of their congregation. With mental illness can come confusion of identity, meaning and understanding, and for a religious person they need time to work out these elements in their spiritual lives. Julia summed up what service users need:

I think you have got to give them time. You have got to give them time to talk about what they are going through, and to listen to them and not necessarily just dismiss it because you think ‘well they are going through an illness so therefore everything they say must be rubbish’. You mustn't dismiss it. (RI:254) Julia 45-64 years

Many service users lose contact with friends when they become ill and seldom make new ones outside the mental health service while they are ill. However, those with religion as an interest seem more likely to make friends outside the service although these are mainly with other religious people who appear more patient and tolerant.

I think that I was so happy at having a measure of acceptance in this group so that as long as people didn't laugh at me, which they didn't in the church group because there was a large measure of acceptance, that I didn't really care. I just kind of continued to act weirdly. (RI:257) William 35-44 years

8.6 Conclusion: The Search for a ‘Protective Cocoon’

Macmin and Foskett (2004:29), in their article “Don’t be afraid to tell”, noted two important reasons which led their service users to talk: “in order to gain comfort from horror, trauma and loneliness of their distress”, and “to find some meaning in what they had to endure”. Their research was led and executed by people who suffered with
enduring mental health problems whose enquiries may have been biased towards issues that were of concern to them. Few of my respondents dwelt on horrifying and traumatic distress possibly because I had not asked them about such feelings, but Macmin’s service users may have done so as it may have been their experience of mental illness. However, many of my respondents were looking for meaning in “what they had to endure”.

They looked to their religious faith to provide an anchor to their habitual thought processes when mental illness threw them into chaos. Their faith provided ontological security, and gave them some stability when life seemed hopeless due to depression, or fragmented when suffering a psychotic breakdown. They also looked to their religious beliefs to heal the breaches in their ‘protective cocoon’ that was often damaged by their illness and other life events.

The largest group of respondents had not spoken about their religious nature to the medical professionals because they were never asked, and they did not volunteer any information because they feared that it would be dismissed as symptomatic of their illness. Sometimes it was enquired about on first admission, but for many people that had been many years before and it had not been talked of since. All my respondents had a religious interest and many had changed greatly over the years. For some their religious side had deepened and for others it had dissipated. Most felt that it had not gone away and some would have liked it to have been taken into account by the medical professionals as part of their lives. However, if they suffered with a mental illness and were religious the two were usually compartmentalised rather than any confluence acknowledged.

A particular concern of many respondents was the fear that their religious notions would be pathologised and belittled as merely part of their mental illness. This concurred with the Mental Health Foundation’s finding that a person’s inner identity and selfhood can be destroyed by invalidating their religious belief system, particularly when already made fragile by mental illness.

To invalidate a person’s spirituality no matter how distorted it is, is to invalidate the real core sense of self and I think that once you do that you risk doing untold damage to somebody. (Nicholls 2002:22)

Some merely feared that this would happen if they discussed their religious lives, while for others it was a reality. This was exacerbated if the medical professional did not hold the same worldview or had no knowledge of the religious norms of the service user.
Many of the respondents relied on each other to encourage their religious faith, as few had much contact with friends outside the mental health service and their families often did not share their religious notions.

Communication is a fundamental skill of human beings and if speech is not established as a baby, the ability to talk is always diminished. In the same way, to hinder the development of communicating religious interests and needs in people who develop a mental illness can lead to an inability for them to gain a full understanding of the world around them when their thinking has been altered by the illness. Professionals who are responsible for their care should take a holistic view of their clients and enable them to speak about all aspects of their lives. They need to understand that for some service users their religious beliefs can be used to restore their ontological security, and that the damage caused to their protective cocoons by childhood experiences and life events may be at the root of some mental illness.
9.1 Introduction
This thesis has been a journey of enquiry. Using an inductive empirical approach it has been possible for me to formulate an understanding of an event which occurred to me nearly four decades ago: an encounter as a young student with severely mentally disturbed patients as they attended the Anglican Morning Service in the large church within a Victorian asylum where I was working. Religion was never mentioned in our Psychiatry lectures except a brief reference to ‘religious mania’. However, hospital churches were a feature of all the large English asylums and as I had found out were evidently not used just by the staff. Therefore, I reasoned that some mentally ill people must have been ‘religious’, and wondered if they were patients who suffered from ‘religious mania’, or were there some who had religious interests and needs as did people who were not confined within a long stay mental hospital? Some light was shed on this question many years later when I discovered that ex-hospital patients went to community clergy for help (Fellowes 1996), but the clergy did not see them as suffering from ‘religious mania’ – they were simply people living in the community who happened to be treated for a mental illness. Further insight was gleaned from McKerrow and Faulkner’s (1997) study, which was instrumental in uncovering the importance of religion in the lives of a high proportion of people with enduring mental health problems.

This chapter will summarize relevant signposts on the journey within this thesis, and attempt to answer the overarching question posed in Chapter 1 – “Why did ‘patients’ then and ‘service users’ now look to religion, and what do they find there?”

It is also important to answer a supplementary question: ‘What are the implications for the medical professionals, the clergy and churches, and indeed ‘the community’ in general which arise from the empirical data relating to the religious experience of service users?’

9.2 Service Users
This research marks the culmination of many years of working with people who have been disabled by physical or psychiatric ill health, in some cases both. In that period
more social changes have taken place in the lives of people with enduring mental health problems than in the preceding century, during which time for the most part they were incarcerated in large asylums away from contact with the rest of society. Although some of the social changes came about through new conceptions of mental illness and its treatment, many of the modifications were made possible, or at least supported, by the introduction of new chemical medications from the early 1950s onwards, although Sargent’s (1967) prediction that the new psychotropic drugs would eliminate mental illness by the year 2000 has sadly proved unfounded.

As has been noted within this thesis, most of the research in this field has been undertaken by professionals, both medical and sociological, for the benefit of medical and academic audiences and has concentrated on issues of interest to such groups. Very little research has endeavoured to understand the consequences of mental illness from the perspective of those suffering with mental health problems. I would posit that despite the structural and legal changes in their care, service users remain a stigmatised group of people whose condition is viewed in negative stereotypical ways embedded in the culture and which pervades the understanding of the general population from childhood, and is frequently reinforced by the media. It is understandable, therefore, that until recently very few people have looked to the service users themselves to contribute knowledge and insights, let alone empower them to undertake their own research.

Many people still have scant contact with people with enduring mental health problems, who despite living in the community have very little close interface with the community on a personal basis; their friendships are mostly with their families and other service users. Indeed Parker et al’s (1995:6) proposition that fear of mental illness took the place once occupied by leprosy at the end of the Middle Ages has some resonance today. Misunderstandings about the aetiology of mental illness concomitant with the fear of its unpredictable presence in society (Laurance 2003) promote stigmatisation and avoidance of sufferers. This may account for the finding, shown in Chapter 5, that the mentally ill are much less likely to belong to clubs than the general population, and indeed although the same proportion as the general population attended church at least once a month, very few who went to a mainstream church knew many people in the congregation, and they were hesitant about discussing their mental health problems with them. Those that lived in ‘group-homes’ or ‘in-patient’ facilities in the community were particularly likely to feel stigmatised because their housing identified them as mentally ill, and there had been opposition from some neighbours to several of the homes when
they were established. As I showed in Chapter 5, among my sample of service users it was significant that only 39% of service users living in such accommodation knew their neighbours in contrast to 75% who lived with their families. Those living with their families may not have been labelled as mentally ill because they were not associated with designated housing, or the non-mentally ill members of the family may have made contact with the neighbours and incorporated the family member into their own friendship and neighbourhood networks.

One of the stereotypic views of mental illness that is germane to this research is that associated with the notion of 'religious mania' – although not a term used by modern professionals it remains in common parlance and was used by several of my respondents to explain their pre-occupation with religious matters. It implies that any expression of religious beliefs and needs by someone with a mental illness is a manifestation of their illness, rather than an intrinsic element of their healthy psyche. This is unjustified, because as this research has shown, the religious interests, beliefs and practices of the respondents were very similar to those of the general population, except in their higher beliefs in the more frightening side of Christianity – 'hell' and the 'Devil', and to a lesser degree their beliefs in a potential escape and reward system – 'heaven' and the 'afterlife'. People without a diagnosed mental illness who hold even extreme fundamentalist religious views may be scorned for their beliefs, but their religious perspective would not be imputed to psychopathology. This may point to the powerlessness of most people with enduring mental health problems. Not only may they suffer with fragmented thoughts, exaggerated fears, and dependence on others, but if they stand their ground to argue their case, particularly in matters religious, this may be diagnosed as symptomatic of their mental illness and they may be sectioned under the Mental Health Act 1983. This fear was mentioned by several respondents with a mixture of anxiety, anger and resignation, and it remains a powerful social control of the mentally ill. No other group in Great Britain can lose their liberty for merely speaking their mind, unless they infringe laws such as incitement to racial hatred or violence.

9.3 Researching Service Users

Researching the religious experiences of people with enduring mental health problems was problematic on several accounts. As a vulnerable group of people they were protected by a series of gatekeepers. To undertake research with them many impediments had to be overcome: the protocols of the study had first to be passed by Ethics Committees who were wary of qualitative social science methods; the medical
team who treated the service users had to give their permission; the key workers who were responsible for the day-to-day care of the service users had to be in accord with the research, as they could encourage or discourage the co-operation of their clients; staff working with the users in any capacity had to be kept informed because they could object to the research; family and carers had to be considered because they could discourage co-operation; and most important of all the service user had to be willing to participate in the study. Having negotiated such hurdles there was a requirement to maintain the access both physically and socially on a regular and ongoing basis. My research nearly came to an abrupt conclusion after eighteen months work, despite approval being granted by three Ethics Committees, when one social worker objected to my being given the names and essential details of the sample population, such as key workers and location of the service users, because I was no longer employed by the NHS Trust. Despite having the Ethic Committees’ approval, without my status as an ‘insider’ of the Psychiatric Service and well known to most of the gatekeepers, his opinion could have swayed the team and my way would have been barred. Despite having gained official approval there was always the fear that permission might be withdrawn at any time, for any reason and at any level.

It was possible that the topic of my research could have made all the layers of gatekeepers extra cautious. As has been claimed, ‘religion is psychiatry’s last taboo’ (Foskett 2004b:5), and I was investigating this unknown territory within a vulnerable group with the potential of unleashing hidden tensions, delusions and fears. Although most of the interview schedules were completed uneventfully, one woman became disturbed with her key worker after the initial interview because speaking about religion brought back anxieties about her actions in a church decades before, and a man became extremely agitated during the initial interview at the mention of the words “sacrament and communion”. With such an unstable sample it was never possible to predict the reactions to the questions particularly in the initial interview, nor anticipate behaviour or rituals that might be precipitated by the interviewing process; one man had to complete a series of press-ups before and after both interviews. If the interview caused an upset it was difficult to comprehend the reason for this because it would usually relate to an issue within the respondent rather than to the interview itself, as shown by the examples above. I neither commented on nor asked the respondents about their views of the interview as I wanted to make the exchange as undemanding as possible, and this would not have been accomplished if the service users had been asked to reflect on their
experience. Feedback sometimes came through the key workers or other staff, although at the commencement of one in-depth interview a woman explained to me that she was happy to speak into a microphone but was so anxious in the initial interview because of the interview schedule: written papers reminded her of the unhappiness of “feeling stupid” at school. This elucidated her initial reluctance to undertake a second interview which turned my expectations upside down; I had been led to believe that respondents were unhappy with being recorded (Fielding 1993:146-147). There were no ‘norms’ when working with my sample.

For me there was no feeling of security throughout the whole interviewing process, which extended over a period of two years mainly because it was so difficult locating the service users at a time, in a place and during a phase of their illness when they were willing to be interviewed. Appointments would be broken with scant reason given and sometimes I would not discover this until after arrival at the agreed location. Usually after several abortive attempts the interview would be completed. Each day brought new challenges and disappointments, but also great rewards and much data collected. In fact I found it was simply an exaggerated experience of working with people with enduring mental health problems – there was never room for complacency because life was so unpredictable, although there was no danger of boredom or repetition and much fun to be had. Perhaps for researchers unused to such a way of life the sample population would have been unnerving. However, to enable such a vulnerable group to examine and speak about their inner lives it was essential genuinely to enjoy their company as people, and to be intensely interested in their communication no matter how wide of expected norms it was. It did make it difficult in the second interview to follow a planned path and focus on a predetermined set of questions, but this reflected the lives of my respondents which were not well-mapped and signposted areas, and the whole aim of the research was to wander around the landscape of religion to find out what hidden contours might be discovered. What for me was a journey of academic discovery, was for some respondents a voyage of personal enlightenment. Only time will tell the benefits such a journey was for them, but one woman was amazed to find after the second interview how fundamental to her whole being her religious life was, and many were grateful to have a professional take a profound interest in this part of their identity.

Personally I benefited from having a new role; that of ‘sociologist’ instead of ‘occupational therapist’, as it afforded me the opportunity to enquire in depth about an
issue that was of interest to me. I felt that as a member of staff it would have been unethical to have undertaken an investigation of an area of their lives that was neither of their choosing nor of any obvious benefit to them, but as a sociologist they knew that I was there to undertake research not to treat them and they had the opportunity to refuse to see me, which some did.

In fact it was an interesting exercise in the balance of power. As has been noted in this thesis there is a power imbalance between service users and mental health professionals, with the professionals in a stronger position, particularly the doctors who in conjunction with a social worker have the authority to compulsorily detain a person. However, as a researcher the power balance was reversed and I was in the weaker situation. I was aware that to keep all the barriers to the research open I had to be amenable to everyone and particularly deferential and accommodating to the service users. Although this was not a problem for the research process I was aware that it was very time consuming, although essential. This will be discussed further in section 9.6.

Some service users were happy to speak briefly about their religious nature to complete the interview schedule but did not want to open up deeper areas that made them anxious, because their religious experiences were sometimes intertwined with fearful religious notions and images that were often heralds of a breakdown, or reminded them of past illnesses. A few were wary of all matters to do with religion, especially those who had been approached by people canvassing for sects. My ‘insider’ status with the staff and many service users helped me over this hurdle, because I was known to be neither a member of a sect nor to proselytize religion but could be trusted as an empathetic listener.

9.4 Religious Experience of Service Users

As Martin noted, it is important to be cautious about making simple deductions from statistics of stated attitudinal responses, such as “how many believe in God...or call themselves Christians” (1967:52).

It became clear that within my research there were several reasons why it was important to take note of such caution. It was possible for respondents to interpret questions within the interview schedule in different ways, or simply misunderstand the concept being investigated. One man qualified his belief in ‘re-incarnation’ by commenting that his Grandpa had been ‘re-incarnated’. It proved the usefulness of filling in the interview schedule with each service user because I was able to ask him how he knew this was the
case. It soon became evident that his Grandpa had been 'cremated' not 're-incarnated', and he was able to correct his statement and say that he did not believe in 're-incarnation'. Some closed questions may not have enabled respondents to express exactly their personal views and therefore their answers did not give a true reading of their attitudes for statistical purposes. For instance the WVS 1990 'religious status' categories caused upset for several committed Christians who objected to the term 'religious person' as they felt that this imputed religious characteristics that they found objectionable. Again the methodology of filling in the interview schedule with each service user proved beneficial, because I was able to identify that they were saying they were 'not religious' because they objected to the term not because they were irreligious. If they had filled in a written questionnaire a false reading of their attitude would have been recorded, because there would not have been a mechanism to note and work through a respondent's problem with the terminology of the questions.

Another issue that arose during the research, which took place over two years for the reasons explained above, was that service users' lives and experiences fluctuated in ways that would not be so evident in the general population. Their mental illness was subject to variation which could potentially affect all aspects of their lives, not least their interpretation of experiences, memories, attitudes and opinions. Occasionally inconsistencies were noted in their accounts in the first and second interviews, however it has to be recognized that this may occur in any sample. Noted inconsistencies were often due to their change of circumstance brought about by their illness, which affected such areas as work, accommodation, church attendance, religious interest, membership of clubs, and friendships. The fluctuating nature of their mental illness made it more probable than within the general population that their attitudes would differ depending on their state of mind.

However, despite the above provisos, an overall picture of their religious experience emerged within the interview schedule and in-depth interviews. As McKerrow and Faulkner (1997) had found, my sample of people with mental health problems did have a high interest in religion and it did provide many with a means of coping with their illness. However, neither their research, nor anyone else's, had investigated the religious beliefs and practices of their sample from the service users' perspective so that inferences could be made about why the mentally ill look to religion.

As has been mentioned, my data showed the sample to be similar to the general population in many ways: their belief in a 'personal God' or a 'life force'; describing
themselves as 'religious'; thinking about the 'meaning and purpose of life; and church attendance, although they attended fewer church clubs. Most beliefs were more strongly felt: belief in 're-incarnation' was similar to the general population although both samples may have had different understandings of the concept as noted above. However, more believed in 'life after death' and 'heaven'; and twice as many service users as the general population believed in 'hell' and the 'Devil', and thought 'often' about 'death'. A third more of the service users said that they prayed and three times as many said that they felt that they had been 'in the presence of God'. The large variation on the last point may have been accounted for by the use of a differently worded question. However, the fact remained that over half of the service users had felt to have been in the presence of God – the same proportion that McKerrow and Faulkner found to have religious interests and needs.

Sixty-seven of the one hundred service users reported having had a ‘religious experience’, but most of their experiences would not stand out as different from those described by the general population to other researchers (Hardy 1979; Hay 1982; Hay 1990; Pupynin and Brodbeck 2001), except in the curtness of their relating. Some were outside the norm of customary experience, but that is often the nature of a ‘religious experience’ – many of the general public now speak of ‘near death experiences’ and ‘déjà vu’ so that they have become a recognised phenomenon within the culture, and since the Beatles’ era, drug induced visions have been accepted as occurring to non-mentally ill people. Therefore, when looking for any features that might be attributed to psychopathology it has to be acknowledged that interpretation of an experience is culturally specific, so that experiences that would appear outside the norm to a non-religious middle-aged man may be familiar to a young charismatic Christian or a psychotropic drug user. Those experiences described by the Spiritualists, the Devil worshippers and the Jehovah’s Witness within my sample may have been normative within their own subculture, but it was difficult to discern whether the mental illness had embellished the teaching of their group, although reference to ‘aliens’ by one man aroused my suspicions. However, there were some experiences that were described by the respondents as relating to their mental illness and they often contained frightening imagery. Some descriptions I found incoherent although evidently they were meaningful to the service user.

An original coding frame was needed to analyse my sample’s experiences because frames constructed by other researchers (Argyle and Hills 2000; Hardy 1979; Hay 1979;
was not accommodated. Unfortunately this precluded direct comparison with other populations. Analysis alone of the experiences did not elucidate the propensity for religion of my sample. However, together with other factors that pointed to their religious interests, it provided a population of those to investigate further to understand why they turned to religion, and in particular if their religious experiences had been instrumental in that process – for example ‘a religious conversion’.

From the analysis of the data from the interview schedule and the transcriptions of the in-depth interviews, together with my field notes, there emerged a picture of a group of people for whom life was often changeable, perplexing and sometimes frightening. Many interpreted their experiences within a religious framework and particularly when their illness caused confusion and uncertainty they looked for guidance, help and comfort. This concurred with previous research but the question remained ‘why did they look to religion?’, rather than to other sources of help or distraction: medicine; psychoanalysis; self-help groups; hobbies; or sport? In fact, taking a functional definition of religion, Eyre made a case that football fulfils the role of religion in that it contains a communal element, as well as “symbols, language, ritual and emotions” (1997:7) that could be construed as religious in nature. However, her concept of religion put into perspective what my respondents were seeking, because it was found in the transcendent rather than in the ephemeral distractions such as ‘football’. They were looking for the supernatural element contained in Wallis and Bruce’s substantive definition of religion:

...the existence of...supernatural entities with powers of agency...which have the capacity to set the conditions of, or intervene in, human affairs.
(Wallis and Bruce 1992:10)

They were looking for an escape from the traumas of this world to a supernatural world that was controlled by a powerful entity that would intervene in human affairs. Human beings and their interventions had not held the answer to their questions nor been able to transform their suffering. They wanted the religious elements purported to be found in football but they also wanted protection, comfort and help in times of trouble that was to be found in religion that contained a beneficent entity. For most this was to be found in Christianity.

However, I theorised that a high proportion of those with enduring mental health problems looked to God as a nurturer who would repair their ontological security that
the illness had damaged.

9.5 Ontological Security

Within Chapters 7 and 8 the narratives in the recorded interviews were analysed taking two salient themes that had emerged from the data: the religious beliefs and practices of the service users; and the respondents' communication with mental health professionals and others. These two themes were considered within the conceptual framework of ontological security, as first proposed by Laing (1959) and enlarged upon by Giddens (1990; 1991), to explore the possibility that here indeed was an explanation for the high religiosity of people with enduring mental health problems. This theoretical step proved useful, as the essence of many narratives showed the fractured state of the personal identity that had been caused by the mental illness, with the ensuing loss of trust in a world that was frequently experienced as threatening and uncontrollable. The world of the mentally ill would recurrently fall into chaos – the opposite of ontological security.

Giddens asserts that a framework through which ontological security can be attained is actively sought by individuals. It is founded on the trust relationship established in childhood, which gives confidence in the continuity of their self-identity and the constancy of the world around them. The basic trust that a child vests in the primary caretaker encourages the development of a 'protective cocoon' (Giddens 1991) that enables the individual to sustain hope, and overcome adversities throughout life because s/he is secure in the knowledge of who s/he is. It gives the belief, often unfounded in reality, that all of life's problems can be overcome and order restored. In Tillich's (1962) understanding, it gives 'the courage to be'. However, this 'protective cocoon' is easily damaged when reality exposes the individual to the knowledge that life is not ordered and secure, and that chaos is the 'spectre at the feast' of many people with enduring mental health problems.

Early learning of basic trust provides the child with emotional security, which enables the child to differentiate between himself/herself and the outside world, and to maintain self-identity in the face of danger. However, Giddens (1991:43) points out that a poorly developed basic trust can produce feelings of unreality in later life with an inability to maintain a clear sense of continuity of self-identity. Both Laing and Giddens recognise that this element is easily destroyed by mental illness, particularly psychosis, and the threats of the outside world become enmeshed with the individual's self-identity. As Laing (1959:42) expresses it: "the ordinary circumstances of living threaten his low
threshold of security”.

Several themes ran through the narratives which pointed to the importance for the service users of employing a religious framework to enable them to maintain a sense of self-identity, meaning and purpose, particularly when the symptoms of acute illness threatened annihilation and chaos.

Whether religious beliefs provided ontological security appeared dependent on the worldview of the respondents. For those who looked for an explanation of events within a religious framework, religious beliefs provided a rationalization of any occurrences no matter how chaotic or frightening. Such a framework was truly a ‘rock’, to use a Christian metaphor because most of the respondents embraced Christianity, on which to build their lives and maintain stability when mental illness shook the very foundations of their experience of others and the world. Religion repaired breaches in their protective cocoons and provided them with ontological security. However, for those who placed their trust in other means of preserving their self-identity religion did not provide ontological security. These people appeared content to accept the medical model to deal with symptoms of their mental illness and looked to non-spiritual elements to repair their protective cocoons. The choice of where service users looked for restoration of their identity as whole people had to be a personal choice, as it was influenced by deeply embedded notions within their personal makeup and by their life experiences, and could not be enforced by outside agents. Their religious practice often belied the framework used to restore their ontological security, and it was only through close examination of their lives that it was possible to discern where they looked in times of crisis for help and recovery.

One theme that stood out, which has a bearing on the inferences drawn from this research, was the importance of listening and taking note of the service user’s personal interpretation of experiences no matter how wide of the rational, medical model of normal thought processes they may be. Simply dismissing them as outside cultural norms can have very damaging effects on the self-identity and self-esteem of the sufferer and destroy their ontological security. Several respondents retained deep animosity to the medical model being used without incorporating listening therapies that might have helped them understand the processes that were instrumental in the breakdown of their mental health. No matter what model of causation is used to explain mental illness, all people are multifaceted and, in the absence of a known aetiology of mental illness, no avenue to understanding the person should be blocked. Neglecting to
take into account their deeply held religious views can cause fundamental damage to the psyche at a time of maximum vulnerability, and made some respondents who used a religious framework to repair their protective cocoon keep their religious beliefs private. Several service users lived in fear that if they divulged their religious notions then they would be pathologised and dismissed, shattering their whole framework of understanding and explanations of their life experiences. As their self-identity was embedded within their religious framework, they feared that rejection of their framework as mental illness could annihilate their self-identity and cause utter despair. Within the research I found this was more a fear rather than a reality, because only one service user felt that his religious experience had been pathologised, although several reported an increase in medication following disclosure of their religious ideation.

Service users used various elements of their religious beliefs to help in their mental illness: they saw God as representing someone who would love, sustain and protect; they employed prayer, particularly private prayer, as a means of regaining control of their lives; holy texts were used to offer explanations of suffering and conflict, and to give a hope of renewal of a healthy mental state in this world and reward in the next for their suffering endured.

I would concur with Giddens that everyone seeks a framework through which ontological security can be attained, and I would posit that for many people with enduring mental health problems this is a religious framework.

9.6 Implications Drawn from the Research

Too many reports relating to mental illness relate a harrowing picture of chaos, confusion and a neglect of those suffering with enduring mental illness. Perhaps I suffer from complacency, or my sociological perspective was clouded by my status as someone who had been for many years an insider within the Psychiatric Service which treated the service users studied in this research. Without denying the many shortcomings that can be found within any institution or human enterprise, I did not find a sample of people who were traumatised by an establishment that abused their religious nature and profaned that which they designated sacred.

However, there are always areas where improvements can be made with the application of theory founded on knowledge. This research sought to expand the knowledge about the religious lives of those suffering with enduring mental health problems, which had been woefully neglected in the past.
There is the overriding picture of an area of service users’ lives that is overlooked by mental health professionals for a variety of reasons. In our culture religion has become privatised, and religious beliefs are not made public unless the individual chooses to make them known. Those that make it public are often people proselytising their own religion, which increases the desire of most people to keep away from them and keep their own religious views in the private domain. This can have adverse consequences for the mentally ill who may need help to understand their experiences, and be able to distinguish between those that are within the normative bounds of their cultural religious framework and those that are due to a breakdown in their mental health. I would suggest that those most able to perform this role should be the mental health professionals, possibly in conjunction with religious professionals.

On the basis of this present research I would conclude that most service users, with help, would be able to distinguish and categorise their religious experiences as different from mental illness phenomena, and use their knowledge to enhance their recovery. Many objected to being given medicine when they voiced religious ideation. It was not just the fact that they were medicated, but it was the lack of talking through their frightening experiences to help restore their ontological security which caused them upset.

New research, particularly that being undertaken by service users, points to the desire for talking therapies to be incorporated into treatment programmes, as they provide an acceptable mechanism to cope with mental illness. The reality is that talking takes much longer to effect a change than prescribing medication. As I found out when undertaking this research, dealing with people with mental health problems from a position which was less powerful that theirs was inordinately costly in time because we had different agendas: time was not a consideration in their lives as it is to a professional who has to treat a large caseload of people and therefore has to ration the time allotted to each individual. However, in the Psychiatric Service each service user was allotted a key worker who was able to give more time than the doctors to listen to them. Respondents often reported that these would be the people they would talk to about religion if they chose to speak to a mental health professional. Therefore, they would be key to enabling their clients to investigate their religious lives.

The important issue from this research is the place that religion should be given in the therapeutic field. This research has indicated that more opportunity to explore the religious beliefs and practices of the service would be beneficial to all. To the service
user it might bring enlightenment of underlying issues and to the professional it would give them knowledge about the mental processes that their clients employ. However, it is an area that has to be handled gently, by giving an opening to the service user to talk if they so desire and to sort out their experiences but without coercion from the therapist.

The benefit of taking note of service users' religious lives is becoming acknowledged, particularly with the rise in Britain of religions other than Christianity, but note has been taken of the lack of training given to staff in religious matters. This is slowly being addressed.

The other side of the coin is the way that the religious institutions and the community deal with the mentally ill. Many respondents reported the lack of friendliness and acceptance within the churches, and some experienced very damaging notions of the cause of mental illness. Again many people shy away from people with mental health problems because it is very time consuming listening to a person speak about their problems, and time is a commodity that is in short supply in the 21st century. Previous research (Fellowes 1996) noted the pressure of work experienced by most religious professionals as well as the lack of training about mental illness. The Church of England in co-operation with the NHS National Institute for Mental Health has attempted to address the latter by producing a very informed resource document on spiritual and pastoral care of the mentally ill. Tidyman and Seymour (Council 2004:Foreword) sum up part of the element within this thesis, that the mentally ill are not the 'mad axmen' of the popular press but simply people who suffer from a mental illness:

...These people are no different from us and they are our friends, neighbours, relations or fellow church members. Often we might be well aware that something is amiss, but the unease that surrounds mental health can prevent us reaching out to one another. (Council 2004:Foreword)

Those within the psychiatric field would do well to reword that sentence replacing the words 'mental health' with 'religion'.

241
Abukuma, M. 1999 'A Webian Sociology Of Religious Experience',

Advisory Centre for Education 1991 'Advisory Centre For Education. Education A To
Z. Fifth Edition.'

Aist, C. S. 1987 'Pastoral Care Of The Mentally Ill: A Congregational Perspective', The
Journal Of Pastoral Care XL1- December (No. 4): 299-310.


American Psychiatric Association 1994 Diagnostic And Statistical Manual Of Mental
Disorders (Fourth Edition) - DSM-IV., Washington D.C: American Psychiatric
Association.

35(4).


Argyle, M. and Hills, P. 2000 'Religious Experiences And Their Relations With
Happiness And Personality.' International Journal For The Psychology Of Religion

Ashley, B. M. 1975 'Ethics Of Experimenting With Persons', In J. C. Schoolar And C.

Atkinson, P. 1990 The Ethnographic Imagination: Textual Constructions Of Reality.,
New York: Routledge.

Attitudes, B. S. 2001 'British Social Attitude Survey': National Centre For Social
Research.

Back, K. and Bourque, L. 1970 'Can Feelings Be Enumerated?' Behavioural Science
15: 487-496.

Barry, M. M. and Zissi, A. 1997 'Quality Of Life As An Outcome Measure In
Evaluating Mental Health Services: A Review Of The Empirical Evidence.' Soc
Psychiatry Epidemiol 32: 38-47.

Psychological Perspective, Oxford: Oxford University Press.


Press.

Bergin, A. 1990 'Religiosity Of Psychotherapists: A National Survey', Psychotherapy
27: 3-7.

Blaxter, L., Hughes, C. and Tight, M. 1996 How To Research, Buckingham: Open
University Press.


Dunham, H. 1964 'Social Class And Schizophrenia.' American Journal Of Orthopsychiatry 34: 634-646.


Fitchett, G., Burton, L. A. and Sivan, A. B. 1997 'The Religious Needs And Resources Of Psychiatric Inpatients.' The Journal Of Nervous And Mental Disease 185:


— 2004b 'Mental Health, Religion And spirituality: Attitudes, Experience And Expertise Among Mental Health Professionals And Religious Leaders In Somerset.' *Mental Health, Religion And Culture* 7(1): 5-22.


Freeman, H. 1999 'Psychiatry In The National Health Service', *British Journal Of Psychiatry* 175: 3-11.


Geertz, C. 1966 'Religion As A Cultural System.' In M. Banton (Ed) *Anthropological Approaches To The Study Of Religion. A.S.A. Monographs No. 3.*, London: Tavistock.


HMSO 1983 'Care In The Community And Joint Finance.' London: DHSS
HMSO 1989 'White Paper: Caring For People. Community Care In The Next Decade And Beyond.' London: DHSS
HMSO 1990 'The NHS And Community Care Act.' London: DHSS
HMSO 1995 'Mental Health (Patients In The Community) Act.' London: DHSS


— 1993 Asylums And After. A Revised History Of The Mental Health Services: From The Early 18th Century To The 1990s., London: The Atherlone Press Ltd.


McKerrow, J. and Faulkner, A. 1997 'Knowing Our Own Minds - A Survey Of How People In Emotional Distress Take Control Of Their Lives.', London: Mental Health Foundation.


Ramos, M. C. 1989 'Some Ethical Implications Of Qualitative Research.' *Research in Nursing and Health* 12(57-63).


Unwins, D. 1963 'Three Hundred Years Of Psychiatry 1535-1860', In R. Hunter And I. Macalpine (Eds), London: Oxford University Press.


WHO 1946 'Constitution Of The World Health Organization. Official Record Of The World Health Questionnaire 2, 100'.


I am conducting postgraduate research for a Ph.D. at the University of Surrey looking at religious interests and needs of people suffering from mental illness.

To find out if people with a mental illness have religious interests or needs, and if they are being met, I am talking to all Dr [Name of Consultant Psychiatrist]'s patients in the [Psychiatric] Service.

I would very much appreciate your help in answering my questions on this questionnaire which I will fill in while your are talking to me. You are free to check what has been written on the questionnaire and correct any misrepresentation of what has been said.

This study is totally anonymous, and you are free to stop the discussion at any time without if affecting the treatment you receive from the [Psychiatric] Service.

Thank you very much for helping me by answering my questions.

Diana M. Fellowes MSc, Dip COT, SROT.

Senior 1 Occupational Therapist
Consent Form

I have read the information sheet and had the purpose of the Research explained to me, and am happy to take part in this interview.

I understand that should I wish I may stop the interview at any time, and that this will in no way affect the treatment I receive from the Community [Psychiatric] Service.

Signed:

Date:
### Appendix Three
#### INTERVIEW SCHEDULE
#### Showing Data from Initial Interview

**Respondent Code:**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1.</th>
<th>Male (64) Female (36)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2.</th>
<th>Age Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-25 (9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.</th>
<th>At what age did you (or will you) complete your full-time education, either at school or at an institute of higher education.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10-14 years (7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.</th>
<th>What is your present / last occupation? Please specify Open ended question from which the main categories identified were:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Professional (10); Skilled Non-Manual (20); Skilled Manual (11); Semi-Skilled Manual (19); Unskilled Manual (31); Never Worked (4); Other (5).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.</th>
<th>Are you...?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 In full-time employment. (7)</td>
</tr>
<tr>
<td></td>
<td>2 In part-time employment. (1)</td>
</tr>
<tr>
<td></td>
<td>3 Unemployed. (21)</td>
</tr>
<tr>
<td></td>
<td>4 Student: (2)</td>
</tr>
<tr>
<td></td>
<td>5 Work experience. (1) Where?</td>
</tr>
<tr>
<td></td>
<td>6 Sheltered work. (57) Where?</td>
</tr>
<tr>
<td></td>
<td>7 Other Combined (11)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6.</th>
<th>Do you live alone or with others?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alone (29) Family (29) Group Home (38) With Friend (2) In-patient (1) Landlady (1)</td>
</tr>
</tbody>
</table>

| 7. | Do you know your neighbours? Yes (59) No (41) |

| 8. | Do you belong to any clubs? Yes (34) No (66) |

<table>
<thead>
<tr>
<th>9.</th>
<th>If “Yes” which ones? Open ended question from which the main categories identified were:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Church (7); Sport (6); Arts (2); Charity (2); Environment (1); Mental Health (9); Other (6). Note - Some respondents belonged to more than one type of club.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10.</th>
<th>How do you spend you free time? Open ended question from which the main categories identified were:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entertainment (69); Hobbies (50); Socializing (38); Exercise (23); Housework (12); Other (6). Note – Most respondents mentioned more than one way of spending their free time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11.</th>
<th>Have you ever had an experience that you might call ‘spiritual’ or ‘religious’?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (67) No (33) DK (0)</td>
</tr>
</tbody>
</table>

| 12. | Can you describe the experience? Yes (61) No (4) N/A (33) |
13. Whether you go to church or not, would you say that you are:
   a) A religious person. (59)
   b) Not a religious person. (26)
   c) A convinced atheist. (4)
   d) Don’t know. (11)

14. Do you ever attend a church service at Christmas or Easter? Yes (38) No (62)

15. Do you attend any services of a religious group?
   Yes (29) If “yes”, go to question 16.
   No (71) If “no”, go to question 23.

16. Which religious groups do you attend?

<table>
<thead>
<tr>
<th>Religious Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roman Catholic</td>
<td>5</td>
</tr>
<tr>
<td>Church of England (Protestant)</td>
<td>7</td>
</tr>
<tr>
<td>Church of England (Special)</td>
<td>7</td>
</tr>
<tr>
<td>Free Church / Non-Conformist</td>
<td>8</td>
</tr>
<tr>
<td>Jewish</td>
<td>0</td>
</tr>
<tr>
<td>Muslim</td>
<td>0</td>
</tr>
<tr>
<td>Hindu</td>
<td>1</td>
</tr>
<tr>
<td>Buddhist</td>
<td>0</td>
</tr>
<tr>
<td>Other (Please state)</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

17. Apart from weddings, funerals and christenings, about how often do you attend religious services these days?

1. More than once a week (6)
2. Once a week. (12)
3. Once a month. (8)
4. Christmas / Easter days (14)
5. Other specific Holy Days (0)
6. Once a year (2)
7. Less often (0)
8. Never / practically never (58)

18. How many people do you know in your congregation?

1. Almost all (10)
2. Many (8)
3. A few (1-5) (9)
4. None (4)
5. Not applicable (69)

19. Have you spoken to a friend in the congregation about your mental health problems? Yes (18) No (13) N/A (69)

20. Do/did you find people in the congregation helpful when you have problems? Yes (12) No (8) Other (0) Not applicable (80)
21. What do/did you find helpful?

22. What do/did you not find helpful?

23. Did you ever attend the services of a religious group in the past?

   Yes (45)  If "Yes", go to question 24
   No (26)   If "No", go to question 27  Attend now (29)

24. Tick which one then go to question 25.

   Roman Catholic (7)  Muslim (0)
   Church of England (Protestant) (23)  Hindu (0)
   Church of England (Merstham) (1)  Buddhist (0)
   Free Church / Non-Conformist (9)  Jewish (0)
   Other (Please state) (4)  None (56)

25. When did you last attend this religious group?

   Within the past year (5)
   Within the past 5 years (8)
   Over 5 years ago (32)
   Never attended (28)
   Attend now (27)

26. Why did you stop attending?

27. Do you find that you get comfort and strength from religion or not?

   Yes (53)  No (42)  Don't Know (5)

28. Were you brought up religiously at home?

   Yes (53)  No (47)  Don’t Know (0)  Other (0)

29. Have you ever felt that you were in the presence of God?

   Yes (53)  No (46)  Don’t Know (1)  Other (0)

30. How important is God in your life – 1 means not at all important and 10 means very important.

   1 (20)  2 (2)  3 (6)  4 (7)  5 (14)  6 (6)  7 (3)  8 (9)  9 (3)  10 (30)
31. How often, if at all, do you think about the meaning and purpose of life?

<table>
<thead>
<tr>
<th></th>
<th>Often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes</td>
<td>(34)</td>
<td>Don’t know</td>
</tr>
<tr>
<td>Rarely</td>
<td>(15)</td>
<td></td>
</tr>
</tbody>
</table>

32. Do you ever think about death?

<table>
<thead>
<tr>
<th></th>
<th>Often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes</td>
<td>(38)</td>
<td>Don’t know</td>
</tr>
<tr>
<td>Rarely</td>
<td>(16)</td>
<td></td>
</tr>
</tbody>
</table>

33. Which of the following statements comes closest to your beliefs:

- a) There is a personal God. (34)
- b) There is some sort of spirit or life force. (46)
- c) I don’t really know what to think. (8)
- d) I don’t really think there is any sort of spirit, God or life force. (8)
- e) Other (4)

34. Which, if any, do you believe in: Tick as many as apply to you,

- a) God (71)
- b) Life after death (59)
- c) A soul (79)
- d) The devil (62)
- e) Hell (53)
- f) Heaven (70)
- g) Sin (80)
- h) Resurrection from the dead (52)
- i) Re-incarnation (35)

35. Do you have a crucifix or St. Christopher medal or any other holy objects? Yes (56) No (44)

If yes, what ____________________________________________________________________________

36. Do you believe such objects can protect or help people?

Yes (42) No (52) DK (6)

37. Do you have a mascot or talisman, or any other lucky charm? Yes (20) No (80)

If yes, what ____________________________________________________________________________

38. Do you think such objects can help or protect you?

Yes (22) No (75) DK (3)
39. Do you read your horoscope?

1. Every day (7)
2. At least once a week (14)
3. At least once a month (7)
4. Less often (27)
5. Never (45)

40. How often do you believe this has an affect in your life?

1. Always (3)
2. Most of the time (2)
3. Sometimes (11)
4. Not very often (15)
5. Never (69)

41. Do you ever pray, meditate or contemplate, or something like that. Yes (66) No (34)

42. How often do you pray to God outside of religious services?

1. Often (31)
2. Sometimes (14)
3. Hardly ever (5)
4. Only in times of crisis (14)
5. Never (36)

43. Please rate the following statements on the scale 1 to 5. 1 is very unimportant and 5 is very important.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>To know God’s presence with me.</td>
<td>(24)</td>
<td>(7)</td>
<td>(14)</td>
<td>(13)</td>
<td>(42)</td>
</tr>
<tr>
<td>To have a purpose and meaning in life.</td>
<td>(2)</td>
<td>(4)</td>
<td>(4)</td>
<td>(26)</td>
<td>(64)</td>
</tr>
<tr>
<td>To be relieved from the fear of death.</td>
<td>(16)</td>
<td>(4)</td>
<td>(22)</td>
<td>(17)</td>
<td>(41)</td>
</tr>
<tr>
<td>To be able to pray.</td>
<td>(25)</td>
<td>(2)</td>
<td>(7)</td>
<td>(20)</td>
<td>(44)</td>
</tr>
<tr>
<td>To have the sacraments and communion.</td>
<td>(55)</td>
<td>(9)</td>
<td>(5)</td>
<td>(11)</td>
<td>(20)</td>
</tr>
<tr>
<td>To have the care and support from another person.</td>
<td>(2)</td>
<td>(3)</td>
<td>(6)</td>
<td>(15)</td>
<td>(74)</td>
</tr>
<tr>
<td>To have a clergyman or woman visit and pray with me.</td>
<td>(55)</td>
<td>(12)</td>
<td>(8)</td>
<td>(16)</td>
<td>(9)</td>
</tr>
</tbody>
</table>

44. Have you spoken to a clergyman or woman about your mental health problems? Yes (44) No (56) If “Yes” go to 45. If “No” go question 48
45. Was this:
   1. In hospital (13)
   2. In the community (10)
   3. In your church (7)
   4. Other (1)
   5. Several (19)
   6. Nowhere (50)

46. If 'yes', did you find this helpful?  Yes (38)  No (6)  Not Applicable (56)

47. Is there anything that would have made it more helpful?  Yes (7)  No (33)
   Not Applicable (60)

48. Would you be happy to talk about any religious ideas or religious experience with a doctor or some other medical person? Yes (45)  No (55)

49. Have you ever spoken to a doctor or someone else medical about your religious experiences, views or needs?  Yes (30)  No (70)
   If "No" go to question 56

50. Who was this?
   1. Consultant (25)
   2. Senior Registrar (9)
   3. Registrar (9)
   4. Occupational Therapist (8)
   5. C.P.N (9)
   6. Other (4)

51. When was this?
   1. Within last 6 months (15)
   2. 6-12 months ago (1)
   3. 1-2 years ago (5)
   4. 2-5 years ago (1)
   5. more than 5 years ago (6)

52. Did you feel your beliefs were understood?  Yes (18)  No (11)

53. Did you feel your beliefs were respected?  Yes (21)  No (8)

54. Did you feel your beliefs were shared?  Yes (10)  No (18)  D/K (1)

55. Did you find discussing your religious experiences, views or beliefs:
   1. Helpful (13)
   2. Unhelpful (8)
   3. Damaging to your faith (0)
   4. Confusing (1)
   5. Other (4)

56. Would you be prepared to answer some more questions in the form of a taped interview?
   Yes (40)  No (4)  Not Applicable (54)  Maybe (2)
Appendix Four
INFORMATION SHEET FOR SECOND
RECORDED INTERVIEW

I am conducting postgraduate research for a Ph.D. at the University of
Surrey looking at religious interests and needs of people suffering from
mental illness.

Thank you for taking part in the original part of this study by answering
the questionnaire, and for agreeing to speak to me in more depth about
your religious experiences.

I will be tape recording our conversation for analysis and the tapes will be
kept securely in a locked container and not used by anyone else. If, at any
time during or after the interview you decide to withdraw from the
research, the tapes will be destroyed. This will not affect the treatment
you receive from the [Psychiatric] Service.

If after you have recorded the interview you feel unhappy with the
recording you are free to listen to the tape. If you are still unhappy with
the recording it will not be used in the analysis and will be erased.

Thank you very much for helping by telling me of your experience.

Diana M. Fellowes MSc, DipCOT, SROT.
Senior 1 Occupational Therapist
Consent Form

I have read the information sheet and had the purpose of the Research explained to me, and am happy to take part in this interview.

I understand that the interview will be tape-recorded and will be used anonymously by Diana Fellowes for the Research. The recording will not be used for any other purpose and will be kept in a locked filing cabinet.

I understand that should I wish I may stop the interview at any time, and that this will in no way affect the treatment I receive from the [Psychiatric] Service.

Signed:

Date:
## Appendix 6. Profile of Respondents who had a Religious Experience

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGNES</td>
<td>35-44</td>
<td>Group Home</td>
<td>Religious</td>
<td>10</td>
<td>None</td>
<td>Never attended</td>
<td>18</td>
<td>Cleaning</td>
</tr>
</tbody>
</table>

### Experience theme: 1. Presence of supernatural – (i) God

5. Extraordinary experience (iii) healing

Last year my father had a stroke. I was thinking of the Holy Spirit and wondering if It will tell me anything. I felt It saying that there was something wrong at the back of my head. One hour later my sister phoned to say about the stroke. I had pain in the back of my head and threw up at 5pm. Waking up in the dark I saw my father in a dark ward, everyone was ill. A silent hand glowing from the Holy Spirit came down on his head. I heard a metallic boom. His soul left his body. Tell the nurse he is healed. I phoned the next day. I had been in hospital and said that Christians had prayed for him. He was discharged five days later. I feel Christ healed him. When you are mentally ill you are more in tune with the other side. I believe he heals you all the time.

When I was 18 I went to see a faith healer Harry Edwards. He said that he was going to have a heart attack and not to grieve for him. I saw a candle alight and heard a voice saying he had a heart attack and not to grieve. Looking at the newspaper the next day it said on the front page at the right hand corner and on the news that he died age eighty-two.

Another dream. I was very ill vomiting for six weeks before Easter. Easter night I saw him pouring tea in the house. He took out to stroke white rabbits twenty-four hours after he died. Easter night is when people rise from the dead.

### Experience theme: 6. Reflexive

I thought that I was going to be a priest, I felt that I was told to do it. I was called by God. It was an inner experience.

Alex would not describe his experience.

### Experience theme: 2. Prayer.

I was brought up a High Church Anglican. I worked a lot at St. [name] as Parish Secretary and ran the young wives group, was on the PCC and Diocesan Rep when my youngest son was 6 years old. I have had answers to prayer on many occasions and learnt through being mentally ill the benefit of intercessory prayer. I have been led to people who really prayed.

In 1957 when I was confirmed at the age of eighteen, I was confirmed because I wanted to be married. I had to be baptised in February and married in March and confirmed in April. When the Bishop put his hands on my shoulders I had a feeling of calm and it remained there for weeks. I had never been a churchgoer then went to church with my husband. Since I have felt so awful my religion has gone. I get very upset when I think about it.

When I was ill I went to church and pleaded with God and nothing came. I know something is out there but I don’t know what. I knew inside there was something there and I was very happy.

Experience theme: Extraordinary experience – (iii) healing.

A long, long time ago I used to go to church to a toddler group. I got involved in Open Doors learning about God. Before I became ill and had a drink and drugs problem I was running the youth work in the church. When I became ill I went to church and one strange thing happened. One day the drinking was bad and I had been up most of the night. I went to church and thought that everyone would have a go at me. I felt awful and couldn’t see the cross. Say floor, say slats. I said if God could make me better I would believe. I went out of the church and realised that I was seeing again. I could see again and there was no tremor. I told someone what had happened and he said it was the power of God. It was the strangest thing. I was to go for detox and felt that I would die. As a last straw sort of thing I went to the church. That was six years ago.

Experience theme: 4. Physical sensation – (iii) hearing.

When I was ill, mentally, I thought I heard Jesus telling me to get a tattoo done two years ago to prove that I believed in him.

Experience theme: 2. Prayer

Answered prayer. I’ll give you an example. I pray that I’ll see [daughter’s name] and not have to wait long. Well I don’t see [daughter’s name] but I pray that I’ll talk to her. I panic a lot if she misses a phone call. And I find that somehow she always turns up.
Experience theme: 1. Presence of the supernatural – (ii) other supernatural.
I practice devil worship. The other night I was talking to milk cartons. It felt like there was another power in the room which came on to me. It felt good like I had more strength than I really had.

[Name] (Hospital Chaplain) used to visit when I was first ill. I had terrible feeling towards my daughter. I thought that I was an evil person. [Name] sat with me for a long time and made me see that I was not an evil person but only had evil thoughts. It was a sudden breakthrough and since then I have got better.

Experience theme: 6. Reflexive
I firmly believe the God is going to do something about wickedness. I go to the Jehovah Witness Hall. I think that I have more advanced knowledge than they do about an alien race. Aliens may destroy the wicked when they come.

I smelt the sewers of Hell, and was visited by the prophet Elijah. The Devil gave me a warning.

Experience theme: 1. Presence of the supernatural – (ii) other supernatural.
Although I was very upset when my brother died, within 24 hours of his death I felt really OK and in touch with his spirit as it left his body. I felt it was a religious experience that he wasn’t suffering anymore and that death wasn’t so bad.

When I was four years old I had a RC au-pair who took me for walks and told me that my parents were Protestant and that there are lots of other religions – Baptists and Charismatics. I went through into a stream and talked in tongues. I baptised myself and I was baptised in the Holy Spirit in one go. She got very upset because I got wet but she said that she would pray. It was probably triggered by a sermon. We went to a cold evangelical church. She spoke of other kinds of churches and ecumenical experiences.
BETHY 45-64 Group Religious 10 None Never attended 16 Cleaning

Experience theme: 5. Extraordinary experience – (iii) healing

I was very poorly for three years and lost my memory but it came back again. It was a great shock, like a miracle. I didn’t know anything about it. My daughter went to India and I did things I didn’t know anything about. I went to McDonald’s and came out crying and crying. It was Christmas and very cold. I slept on the floor with an electric blanket. A friend came into the shop and came upstairs and found the blanket touching the fire — she said she had no idea about anything. I was taken to hospital.

CHLOE 35-44 Family Religious 10 Other: Brethren More than once a week 22 Professional

Experience theme: 4. Physical sensation – (iii) hearing.

When my Nan died I was tenish and I didn’t know that she had died. I thought she spoke to me although she lived in Devon to say that she is OK. Next day I found that she had died. I still speak to her now if I feel low.

CLARE 45-64 Family Religious 10 Other: Brethren More than once a week 22 Professional

Clare said that she had had an experience but did not want to describe it.

DANIEL 26-34 Group Home Don’t Know 5 None Attended within 5 years Free Church 16 Unskilled manual

Experience theme: 4. Physical sensation – (iii) hearing.

Sometimes it’s like someone talks to you — sounds like Jesus. It makes me think more about Jesus.

DYLAN 26-34 Alone Religious 5 None Attended 5+ years ago. C of E 19 Professional

Experience theme: 4. Physical sensation – (iii) hearing.

When I started hearing voices I could hear deep speaking coming from the devil people and pointing down I could hear higher notes coming from upper angelic voices. They were talking amongst themselves and me.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>Tea</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HENRY</td>
<td>45-64</td>
<td>Alone</td>
<td>Religious</td>
<td>1</td>
<td>None</td>
<td>Never attended</td>
<td>15</td>
<td>Skilled manual</td>
</tr>
<tr>
<td>HUGH</td>
<td>35-44</td>
<td>Group Home</td>
<td>Religious</td>
<td>10</td>
<td>C of E</td>
<td>Weekly</td>
<td>16</td>
<td>Unskilled manual</td>
</tr>
<tr>
<td>JACK</td>
<td>35-44</td>
<td>Group Home</td>
<td>Don't Know</td>
<td>1</td>
<td>None</td>
<td>Attended 5+ years ago. C of E</td>
<td>17</td>
<td>Unskilled manual</td>
</tr>
<tr>
<td>JACOB</td>
<td>26-34</td>
<td>Alone</td>
<td>NR</td>
<td>1</td>
<td>None</td>
<td>Attended 5+ years ago. C of E</td>
<td>22</td>
<td>Unskilled manual</td>
</tr>
<tr>
<td>JOAN</td>
<td>35-44</td>
<td>Alone</td>
<td>NR</td>
<td>8</td>
<td>None</td>
<td>Attended 5+ years ago. Other: Black Magic Group</td>
<td>15</td>
<td>Cleaning</td>
</tr>
<tr>
<td>JOE</td>
<td>26-34</td>
<td>Group Home</td>
<td>Religious</td>
<td>5</td>
<td>None</td>
<td>Attended within 5 years. Free Church</td>
<td>16</td>
<td>Unskilled manual</td>
</tr>
</tbody>
</table>

**Experience theme: 4. Physical sensation – (v) see**

My great grandfather lived at Southend and I saw the sea on fire. For six months it left a great impression.

**Experience theme: 1. Presence of the supernatural – (i) God**

I have had multiple visions – mental images. When I was suffering I closed my eyes to sleep then suddenly my eyes opened a little bit. I had a vision in colour of mainly trees, and flowing leaves in the wind. I hear God saying 'there, there, we are here'. It was like watching the telly. Not long, seconds. God was comforting me. I heard on the radio that visions are warnings but this was not a warning it was God showing me that he was there. I had visions at the start of my cataracts – it gave me comfort when I was upset with the loss of my sight. I still get them.

**Experience theme: 4. Physical sensation – (i) high.**

When I was ill I went high and felt great emotional love about the human race. I felt that the world was to do with love.

**Experience theme: 1. Presence of the supernatural – (ii) other supernatural**

Oak trees. I had a vision of the mythical celestial oak. It influenced my creativity. I am a potter. This was ten years ago and I was living on my own at the time. I was taking marijuana.

**Experience theme: 4. Physical sensation – (v) see**

I have seen a man who disappeared into thin air and spoke French. It was an eye opener. It made me feel if I did die I wouldn't be alone because He cared. I thought I was dying. I think it was like a person who cared like a vampire. Energy.

**Experience theme: 1. Presence of the supernatural – (i) God**

In the past I have been on me own but I haven't felt alone you know. It is as if someone is there but I can't see him. The only explanation I have got for it is it has got to be God like
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOSH</td>
<td>35-44</td>
<td>Group Home</td>
<td>Atheist</td>
<td>1</td>
<td>None</td>
<td>Never attended</td>
<td>28</td>
<td>Factory</td>
</tr>
</tbody>
</table>

**Experience theme: 5. Extraordinary experience – (iv) warning**

I thought that I saw the death figure once. It looked like the old man with a scythe. I went out for a walk one night in the Shetlands. I looked around and saw the Grim Reaper. I thought ‘don’t run’. As I walked I came to a quarry. If I had run I would have gone over the edge into the quarry. I don’t know if that was a warning or someone trying to kill. It was twenty years ago.

<table>
<thead>
<tr>
<th>JULIA</th>
<th>45-64</th>
<th>Alone</th>
<th>Religious</th>
<th>6</th>
<th>C of E Service Users</th>
<th>Weekly</th>
<th>19</th>
<th>Office</th>
</tr>
</thead>
</table>

**Experience theme: 4. Physical sensation – (i) high.**

It was as a part of my illness. When I am manic I get a religious high. I am aware of the Devil’s presence. I feel that I have to fight the good fight. I play down religion in the normal course.

<table>
<thead>
<tr>
<th>JULIAN</th>
<th>45-64</th>
<th>Family</th>
<th>Don’t Know</th>
<th>3</th>
<th>None</th>
<th>Attended 5+ years ago. C of E</th>
<th>23</th>
<th>Professional</th>
</tr>
</thead>
</table>

**Experience theme: 5. Extraordinary experience – (ii) near death**

Nineteen and a half years ago I came out of the psychiatric hospital. In 1956 I got a job with the Coal Board in Leatherhead. I suffered a compound fracture of my femur playing football and I needed an operation, but I don’t remember much. It was suggested that I go back to Bristol on the train to hospital and I nearly died. I felt the couch floating in the cloud in the sky. My mother said that I nearly died. I dream that mother is holding father’s hand and reaching out to me in the presence of God.

<table>
<thead>
<tr>
<th>KATE</th>
<th>35-44</th>
<th>Group Home</th>
<th>Religious</th>
<th>10</th>
<th>None</th>
<th>Attended 5+ years ago. Free Church</th>
<th>16</th>
<th>Office</th>
</tr>
</thead>
</table>

**Experience theme: 6. Reflexive**

I thought that I was spiritually gifted. I thought that I was entering into another world. After a friend’s death by suicide I had a dream about snakes but not now. I have believed for years that I am spiritual deep down inside.

<table>
<thead>
<tr>
<th>KEVIN</th>
<th>45-64</th>
<th>Alone</th>
<th>NR</th>
<th>4</th>
<th>C of E Service Users</th>
<th>Monthly</th>
<th>15</th>
<th>Skilled manual</th>
</tr>
</thead>
</table>

**Experience theme: 4. Physical sensation – (vi) peace.**

I felt very different, very peaceful after being at [Christian healing centre].

<table>
<thead>
<tr>
<th>LAURA</th>
<th>45-64</th>
<th>Friend</th>
<th>Religious</th>
<th>8</th>
<th>Free Church</th>
<th>Monthly</th>
<th>15½</th>
<th>Shop</th>
</tr>
</thead>
</table>

**Experience theme: 3. Christian – (i) conversion**

At a Billy Graham crusade those who want to know come forward and I did.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious Service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEWIS</td>
<td>35-44</td>
<td>Group Home</td>
<td>Religious</td>
<td>10</td>
<td>Roman Catholic</td>
<td>Weekly</td>
<td>24</td>
<td>Office</td>
</tr>
</tbody>
</table>

**Experience theme: 1. Presence of the supernatural – (i) God**
I felt the presence of God in a small way. He helped me through a bad time.

| LOTTIE   | 26-34 | Group Home | Religious | 8       | None | Attended 5+ years ago. C of E | 16  | Shop       |

**Experience theme: 5. Extraordinary experience – (i) out of body**
When I was five I was waking down the stairs and was floating towards the ceiling. I felt I was right up to the ceiling. I felt very relaxed, good, never felt so at ease. I went downstairs and lay on the couch and felt wonderful. I never saw my own body, just felt floating upwards.

| LUCY     | 45-64 | Family   | Religious | 10     | Roman Catholic | Weekly         | 21  | Cleaning   |

**Experience theme: 1. Presence of the supernatural – (i) God**
When I was picking thyme with my ex-husband [name] I was nominally looking for the Lord. When I put my hand on a leaf it was like Adam touching the finger of the Lord. There was a recognition of something sublime. God was in the World like a benign presence. It made me feel that there was something wonderful to reach out for. It was a time of great searching. It was like the Lord was saying ‘you are important to me’. I found out that thyme has a spiritual connotation. There is a play on the word time/thyme. Parallels in natural – timeless spiritual things.

| LUKE     | 35-44 | Group Home | Religious | 5       | None | Attended 5+ years ago. C of E | 16  | Shop       |

**Experience theme: 2. Prayer**
When I was 26 I was involved with St. [name] Church at [town] and was confirmed. My mother got her eyesight back and I felt that this was an answer to prayer.

| MAGGIE   | 45-64 | Group Home | Religious | 10     | Free Church | Weekly        | 16  | Cleaning   |

**Experience theme: 3. Christian – (i) conversion**
I was converted in Hyde Park by Cliff Richard when I was 18 years old. I went to church then to the Baptist Church and said that I want to know more about Jesus and was baptised, and I felt a great peace from God. The Lord has been with me ever since.

| MATT     | 45-64 | Landlady- | NR        | 10     | None | Never attended | 14  | Unskilled manual |

**Experience theme: 4. Physical sensation – (vi) nice feeling**
I send things right around the world. People can hear whatever I say. Wind came in and there were birds at the back. I was with my sister and someone said “are there bats here”. “Don’t be so silly”. It was a nice feeling.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEGAN</td>
<td>45-64</td>
<td>Alone</td>
<td>Religious</td>
<td>7</td>
<td>Free Church</td>
<td>More than once a week</td>
<td>17</td>
<td>None</td>
</tr>
</tbody>
</table>

**Experience theme: 4. Physical sensation – (iv) heat**

I woke up in the middle of the night and felt a presence at the end of my bed. My whole body was glowing and hot including my feet and everything was yellow. The figure said “what are you going to do now?” The heat and yellowness I gather is a familiar experience of others.

| MIKE    | 18-25 | Family     | Religious | 5                | None         | Never attended            | 16  | None             |

**Experience theme: 4. Physical sensation – (v) see**

When I was ill I felt that I was possessed – it was very frightening. It was probably drug induced. I saw images of things like murders. I haven’t had any experiences since becoming well.

| MORGAN  | 26-34 | Group Home | Religious | 4                | None         | Attended within past year. C of E | 16  | Unskilled manual |

**Experience theme: 1. Presence of the supernatural – (ii) other supernatural**

I have seen spirits/ghosts. Ghosts talked to me from Heaven. When I was twenty-three/twenty-four I saw lights and the top half of my Granny. People were talking to me and I talked to people in Heaven. I was lying on my bed and sent embraces to Jesus in Heaven. I felt my hands and feet were warm.

| MORRIS  | 45-64 | Alone     | Religious | 10               | None         | Attended 5+ years ago. C of E   | 16  | Skilled manual   |

**Experience theme: 4. Physical sensation – (v) see**

I have a memory when I was under ten and was standing on a wall and looked up at the sky and saw a silver spoon. When I was nineteen/twenty I used to go to the employment agencies to look for a job in Croydon. I felt that people were projecting things onto me and I could make them do things. Like I was the owner. It was very frightening. I had to fight it on my own. I felt it was because I was an Italian. I felt it was a spiritual experience.

| OLGA    | 45-64 | Family    | Religious | 6                | None         | Attended 5+ years ago. C of E   | 15  | Shop             |

**Experience theme: 2. Prayer**

I had my first son and my period stopped. I thought that a hand touched my head saying that everything will be OK. I felt a presence. My period come next day. My prayers were answered.

| OLIVER  | 45-64 | Alone     | Religious | 10               | None         | Attended within 5 years. RC     | 25  | Professional    |

**Experience theme: 4. Physical sensation – (vii) hallucinations**

I experienced hallucinations of spirits that frightened the life out of me. I have seen writing in the sky as a message from God – all a frightening part of my mental illness.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PETER</td>
<td>35-44</td>
<td>Alone</td>
<td>Religious</td>
<td>10</td>
<td>Roman Catholic</td>
<td>Monthly</td>
<td>16</td>
<td>Unskilled manual</td>
</tr>
</tbody>
</table>

**Experience theme: 4. Physical sensation – (vii) hallucinations**
In hospital when I was ill after taking lots of drugs I experienced lots of hallucinations

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHILIP</td>
<td>26-34</td>
<td>Group Home</td>
<td>Religious</td>
<td>4</td>
<td>None</td>
<td>Never attended</td>
<td>17</td>
<td>Shop</td>
</tr>
</tbody>
</table>

Philip said that "I have had a spiritual experience but do not want to talk about it."

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACHEL</td>
<td>45-64</td>
<td>Family</td>
<td>Religious</td>
<td>7</td>
<td>None</td>
<td>Attended 5+ years ago. C of E</td>
<td>15</td>
<td>Skilled Manual</td>
</tr>
</tbody>
</table>

**Experience theme: 6. Reflexive**
Every time that my grand daughter comes to see me I think that she is a blessing.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RALPH</td>
<td>26-34</td>
<td>Group Home</td>
<td>Don't Know</td>
<td>4</td>
<td>None</td>
<td>Attended 5+ years ago. C of E</td>
<td>16</td>
<td>Shop</td>
</tr>
</tbody>
</table>

**Experience theme: 5. Extraordinary experience – (ii) near death**
I went to Thailand about 7 years ago and had an experience at a waterfall. I got sucked under the water and thought that I was dying and became extremely calm. It was a near death experience. I came above the water gasping for air. I found out that two years before I went someone had drowned there. I was not panicking, rushed or upset. I was totally calm.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RICHARD</td>
<td>26-34</td>
<td>Group Home</td>
<td>Religious</td>
<td>6</td>
<td>None</td>
<td>Attended within 5 years. C of E</td>
<td>19</td>
<td>Shop</td>
</tr>
</tbody>
</table>

**Experience theme: 1. Presence of the supernatural – (i) God**
I didn't really believe in God until I was really quite ill. You believe in yourself, you believe in your parents, you believe in God but um of course one needed some sign and I felt when I was in hospital I saw a bright star, you know. I found it almost like the star of Bethlehem in the sky. I saw that and I felt that gave me strength and since then I have believed in God wholesale. It sort of gave me the spirit.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROBERT</td>
<td>35-44</td>
<td>Group Home</td>
<td>Religious</td>
<td>10</td>
<td>None</td>
<td>Never attended</td>
<td>16</td>
<td>Factory</td>
</tr>
</tbody>
</table>

**Experience theme: 2. Prayer**
Having faith in God, praying to God and having my prayers answered. Getting out of hospital in 1988.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROSE</td>
<td>45-64</td>
<td>Alone</td>
<td>Religious</td>
<td>10</td>
<td>None</td>
<td>More than once a week</td>
<td>15</td>
<td>Cleaning</td>
</tr>
</tbody>
</table>

**Experience theme: 2. Prayer**

When going to have an operation I was very frightened. People prayed for me on the Tuesday before I had the operation on the Wednesday. I knew that God was there because I felt different. I felt calmer and I looked at the operation in a different light. On the day of the operation I was still frightened but not so frightened.

<table>
<thead>
<tr>
<th>Ryan</th>
<th>35-44</th>
<th>Family</th>
<th>Religious</th>
<th>3</th>
<th>None</th>
<th>Attended 5+ years ago, C of E</th>
<th>19</th>
<th>Unskilled manual</th>
</tr>
</thead>
</table>

**Experience theme: 4. Physical sensation – (vii) hallucinations**

When I took magic mushrooms I hallucinated a lot and I thought it was God talking to me. It was not like a conversation with no-yes. I read Paradise Lost and had experience of seeing devils. It would be frightening if I had not taken magic mushrooms – that took the chill off it. I think religious experiences are when you open your mind with magic mushrooms.

<table>
<thead>
<tr>
<th>Sarah</th>
<th>26-34</th>
<th>Group Home</th>
<th>Religious</th>
<th>9</th>
<th>None</th>
<th>Christmas and Easter</th>
<th>15</th>
<th>Cleaning</th>
</tr>
</thead>
</table>

**Experience theme: 2. Prayer**

I was on the A3 in a car by myself. There was heavy rain. I wondered if I should stop but I continued at 30 mph. There was a huge thunderbolt. I prayed to the Lord to see me through the storm. I was going to Guildford and was very frightened. I was going up to a bridge and all of a sudden the skies brightened. I felt that this was a real answer to prayer.

<table>
<thead>
<tr>
<th>Sharon</th>
<th>45-64</th>
<th>Group Home</th>
<th>Religious</th>
<th>8</th>
<th>C of E</th>
<th>Weekly</th>
<th>14</th>
<th>Shop</th>
</tr>
</thead>
</table>

**Experience theme: 3. Christian – (i) conversion**

I became a Christian in 1989 and gave my life to the Lord. It was a very good experience.

<table>
<thead>
<tr>
<th>Sophie</th>
<th>35-44</th>
<th>Family</th>
<th>Religious</th>
<th>6</th>
<th>Other: Spiritualist</th>
<th>Attended within 5 years.</th>
<th>15</th>
<th>Cleaning</th>
</tr>
</thead>
</table>

**Experience theme: 4. Physical sensation – (v) see**

I have seen ghosts – several throughout my lifetime. I believe in evil spirits. I saw a male person standing on the window ledge – outside trying to get in, dressed in black. I sensed evil and it wanted to come in. I had just come out of hospital.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEPHEN</td>
<td>26-34</td>
<td>Group Home</td>
<td>NR</td>
<td>4</td>
<td>None</td>
<td>Never attended</td>
<td>16</td>
<td>Unskilled manual</td>
</tr>
</tbody>
</table>

*Experience theme: 4. Physical sensation – (i) high*

It was like a tremendous high. I felt very high and airy. It went on for several weeks.

| SUSAN     | 45-64| Family | Religious | 10   | None   | Attended 5+ years ago. RC | 15   | Office |

*Experience theme: 4. Physical sensation – (v) see*

When I was very ill I thought that I saw a guardian angel – I was getting worse and worse. I have a little picture of Jesus and Our Lady and when I felt that a bad force was happening I put the Holy Picture under my pillow. I woke up with a start and saw in the dark a very small guardian angel. The fire was in Christmas at 3pm. I thought of everything in threes. I rang Father Hill and left a message. He came and said “I think that you are ill and need help” I was 32 years old. Reading things upset me. I feel I know when something – I get a cold feeling. I saw a witch. After confession a heat came through me and I didn’t feel frightened.

| TIMOTHY   | 26-34| Family | Religious | 4    | None   | Never attended           | 17   | Skilled manual    |

*Experience theme: 5. Extraordinary experience – (i) out of body*

I had an out of body experience. I was in bed asleep. All of a sudden my body was hurtling out of bed and going down a vortex, blue and spots of different colours. I said SHIT and woke up in the body and it never happened again. It was a year ago and was a bit pleasant and a bit scary. I may have been dreaming.

| TOBY      | 45-64| Group Home | NR       | 10   | C of E Service Users | Weekly | 19   | Professional     |

Toby said that “it is an experience I have everyday and I don’t want to talk about it.”

| TOM       | 35-44| Alone   | Religious | 8    | None   | Attended 5+ years ago. Free Church | 16   | Shop             |

*Experience theme: 1. Presence of the supernatural – (i) God*

I was very religious when I was younger and had a feeling of Jesus within me. When I was fifteen I was camping in a Bell tent. One evening in the two weeks I got up and said is Jesus with us? I was listening. I felt someone saying ‘go on, get up and tell them I’m here’. I felt pushed on to an arena – I felt the push on the shoulder to speak. I got up. I felt Him around me during that fortnight. I had actually always believed in Jesus and God.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Abode</th>
<th>Religious</th>
<th>Importance of God</th>
<th>Denomination</th>
<th>Attends Religious service</th>
<th>TEA</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>TONY</td>
<td>45-64</td>
<td>Alone</td>
<td>Religious</td>
<td>5</td>
<td>None</td>
<td>Attended within past year. Free Church</td>
<td>17</td>
<td>Unskilled manual</td>
</tr>
</tbody>
</table>

**Experience theme: 1. Presence of the supernatural – (ii) other supernatural**

After my wife left me I started going to the Methodist Church. During the first 7 to 8 weeks I felt drawn spiritually to the church. There was more to it than meets the eye. I am an all or nothing sort of person.

<table>
<thead>
<tr>
<th>TYLER</th>
<th>26-34</th>
<th>Family</th>
<th>Religious</th>
<th>10</th>
<th>Free Church</th>
<th>Weekly</th>
<th>16</th>
<th>Shop</th>
</tr>
</thead>
</table>

**Experience theme: 5. Extraordinary experience – (iii) healing**

(v) déjà vu/ premonition

I laid my hand on someone’s shoulder and it clicked back into place and was healed.

I have had lots of déjà vu – second chances. At work I experienced a premonition of someone coming to choose a tile. It took a long time to sort out the problem. This person came in one year later and I recognised her from my premonition and knew what she wanted and therefore could sort out her problem instantly.

<table>
<thead>
<tr>
<th>VAL</th>
<th>35-44</th>
<th>Group Home</th>
<th>Religious</th>
<th>5</th>
<th>C of E</th>
<th>Weekly</th>
<th>15</th>
<th>None</th>
</tr>
</thead>
</table>

**Experience theme: 1. Presence of the supernatural – (i) God**

I do think that God has helped me in some ways you know. I just think He has helped me. Encouraged me to go to church. Just little things really like take part in the bring and buy sales and take part behind the stalls. Be in the choir. Things like that.

<table>
<thead>
<tr>
<th>WALTER</th>
<th>45-64</th>
<th>Landlady</th>
<th>Religious</th>
<th>10</th>
<th>C of E</th>
<th>Weekly</th>
<th>18</th>
<th>Unskilled manual</th>
</tr>
</thead>
</table>


I experienced the filling of the Holy Spirit.

<table>
<thead>
<tr>
<th>WILLIAM</th>
<th>35-44</th>
<th>Family</th>
<th>Atheist</th>
<th>10</th>
<th>Roman Catholic</th>
<th>Weekly</th>
<th>22</th>
<th>Professional</th>
</tr>
</thead>
</table>

**Experience theme: 3. Christian – (i) conversion**

Basically I became a born again member, a Pentecostal Catholic version, at the age of 17. I was speaking in tongues and it was a very intensive social meeting of people. I got a lot of good friends from that. Coming to England on my own knocked it out of me. I don’t belong to that scene any more but it was very intense while it lasted.