‘I’m Spiritual but not Religious’

Implications for Research and Practice

Patricia Casey

Summary

There is an assumption, amongst some mental health service users, clinicians, researchers and others, that religiousness and spirituality are the same construct. A consideration of the history of these concepts shows that, over time, each has become separated from the other. Both require careful definition. The definitions of spirituality are heterogeneous and, with important implications for research and practice, some encompass mood states. The failure to separate spirituality and religiousness, and the confounding of spirituality with mood states in some research in psychiatry, makes interpretation of the findings difficult. Greater clarity and precision will be required in future research including, if possible, attempts to provide distinctive operational definitions of spirituality and religiousness.

Since the turn of the millennium there has been a visible increase in interest among psychiatrists and psychologists in the role of religion and spirituality in illness and health, including mental health. From ambivalence and even downright hostility, the pendulum has swung dramatically and in the 30 years prior to 2000 (Koenig2008) there were 724 quantitative studies on religion/spirituality and mental health in peer reviewed journals while
in the eight years post 2000 there were 6774 such articles published and the majority of these pointed to a positive association between religion/spirituality and mental health benefits. The first handbook of religion and health was published in 2001 (Koenig et al 2001) and a second edition followed in 2012.

The growth of interest in the link between religion/spirituality and mental health was recognized by the development of best practice guidelines by the American Psychiatric Association (1990) and more recently by the General Medical Council of Britain (2008). The American College of Graduate Medical Education now mandates that all students receive training in the religious and spiritual factors that can influence mental health. The Royal College of Psychiatrists in Britain (2011) published a four-page position statement stating ‘there is now a sufficient body of evidence to suggest that spirituality and religion are at least factors about which psychiatrists should be knowledgeable insofar as they have an impact on the aetiology, diagnosis and treatment of mental disorders. Further, an ability to handle spiritual and religious issues sensitively and empathically has a significant potential impact upon the relationship between psychiatrist and patient’. There are now also a number of peer reviewed journals dedicated to publishing on the topic. Some are specific to the study of health and religion while others are broader but also publish papers on health and religion/spirituality. These include:

- *International Journal for the Psychology of Religion*

- *Journal of Religion and Health*

- *Journal of Religion, Spirituality and Ageing*

- *Journal for the Scientific Study of Religion*

- *Journal of Spirituality in Mental Health*
In addition all the major mental health journals are also publishing on this topic (see references below).

Historically the relationship between psychiatry and religion fluctuated. The writings and actions of some early psychiatrists were favourable to the role of religion and spirituality in the care of the mentally ill. The founder of the first mental hospital in Britain, William Tuke, was a Quaker, and he was impelled to charitable works by his faith. ‘Moral Therapy’ was offered to patients. The first psychiatric hospital in Ireland was founded by Dean Jonathan Swift, the Anglican Dean of St Patrick’s Cathedral in Dublin in 1747. Throughout Europe the earliest mental hospitals were founded by religious individuals acutely aware of the mistreatment and pariah status of those with mental illness. The Hotel-Dieu was founded by Saint Landry in Paris in 651, while monasteries offered sanctuary to the homeless mentally ill.

However Jean-Martin Charcot (1825–93), a physician and his pupil, Sigmund Freud (1856–1939), had a more jaundiced view of religion, and they linked psychiatric conditions such as hysteria and other neuroses to it. An exception to this at the time was Carl Jung (1875–1961). The negative view of religion and its relationship to mental illness dominated into the late twentieth century. In 1980, Albert Ellis, the founder of rational emotive therapy wrote ‘devout theists often deny, ignore or hallucinate about reality; the more devout they are – as the long history of religion shows – the more delusional and hallucinatory they seem to be’ (Ellis 1980), while a Canadian psychiatrist Wendall Watters wrote ‘Christian
doctrinal and liturgical practices have been shown to discourage the development of adult coping behaviour and the human to human relationship skills that enable people to cope in an adaptive way with anxiety caused by stress’ (Watters 1992).

It is difficult to identify the reason for the change in attitude but the increased interest among psychiatrists in the role of religion and spirituality in mental health was averred to in the *American Journal of Psychiatry*, which editorialized on the topic (Curlin et al 2007) and commented that the long-standing disinterest among psychiatrists concerning the religious beliefs of patients may be passing.

**Causation or Association?**

The upshot of the increase in interest in religion/spirituality and mental health is that now there are numerous studies identifying positive associations between them in diverse conditions and behaviours including depression, anxiety, suicidal behaviour, coping styles and adolescent behaviour as well as recovery from physical illnesses.

But association does not imply causation. There are two ways to approach this question in science. To show that A causes (or helps) B requires that subjects are randomized to either receiving or not receiving A and then examining the numbers who develop B in each group. Studies of this type are termed controlled experiments. In the case of religion/spirituality, it is not possible to conduct such studies since random allocation to regular religious activities based on faith is generally not feasible or ethical (except for studies of remote prayer) so instead observational studies are conducted.

Observational studies are carried out when A is outside the control of the investigator. In this instance the population under study, say adults in the general population, will be
identified and those who possess and do not possess attribute A (religiousness/spirituality) will be identified and the impact this has on the likelihood of developing B, e.g. depression, will be measured.

But answering the question as to whether it is religiousness per se that influences the chance of developing depression is not so simple. For example, the positive association between religious practice and reduced risk of depression might simply be that those who are not depressed are more motivated to engage in religious practices such as church attendance. Alternatively, it may be that the presumed benefits on mental and physical health are simply due to lifestyle habits that are likely to be more sober in those who are religious/spiritual. Another possible explanation is that the friendship and support people find by regular church attendance is responsible – if so then being a member of a football club would generate equal benefits. In order to answer the question as to whether it is religious practice per se that is cause, these third variables mentioned above such as lifestyle habits and social supports (also called confounders) must be controlled for statistically in the analysis of the collected data.

In addition, questionnaires to measure religiousness and depression must be developed and statistically evaluated to ensure that they are valid (measuring what it is they claim to measure) and reliable (the same results will be obtained when administered by two separate investigators to the same group or when measured on two separate occasions). These methodological requirements are clearly laid out in many statistics textbooks.

The studies must take place in a variety of settings such as the general population, mentally and physically ill in-patients and out-patients and so on and there must be period of follow-up.

It is only when these requirements have been met that a causal rather than an associated link is demonstrated. These criteria have been enunciated by Bradford Hill (1965).
‘I’m spiritual but not religious,’ – Fact or Fiction?

In the area of religious research, religion and spirituality have traditionally been interlinked. The word *spiritualitas* was used first in the fifth century in reference to the influence of God in human lives, while by the twelfth century it referred more specifically to the psychological or interior aspects of the human experience. All the faith traditions developed spiritual dimensions. The Jewish faith saw the growth of the Kabbalah movement, Islam the Sufi movement and Christianity the Gnostics. Individuals also developed their own forms of spirituality, and one such was the seventeenth-century mystic Madam Guyon whose focus was on prayer and ‘Quietism’, a state of intellectual and interior stillness so as to attain perfection and union with God. Saint Theresa of Avila was another. While most of these were condemned to varying degrees (Theresa of Avila is now one of the few female Doctors of the Church), their focus was still trained on God and the Divine. The Enlightenment, culminating in the French Revolution, mounted a challenge to orthodox religion and consequently to the temporal power of the Church.

By the time the twentieth century arrived, the Church’s influence had waned significantly and avowedly atheistic states were on the horizon. The social revolution of the 1960s saw the search for direction and ethical guidance renewed, but not from the Church, which was by now in serious decline. The New Age movement began in England in the 1960s and quickly became international. Devotees did not have group rituals, and nor did they adhere to any single dogma. There was no one learned text to offer guidance. Rather adherents were encouraged to adopt which ever set of beliefs and practices they felt most comfortable with, including meditating, divination (foretelling the future), channelling and so on. Their search was located in the individual and they defined their own gods. Many
Christians have incorporated elements of New Age beliefs into their lives while others, with no affiliation to a traditional theology, have become avid followers of New Age thinking. Elements have been incorporated into political thinking also, such as environmentalism.

The book by Roof (2001) *Spiritual Marketplace: Baby Boomers and the Remaking of American Religion* was a watershed in understanding the new spirituality. For the first time, everybody could appropriate claims to being spiritual, even those who were non-believers.

While previously spirituality and religiously related activities such as prayer, fasting and meditating were inextricably linked, the new understanding viewed spirituality as something that everybody possessed, yet was uncoupled from a religious core. This is illustrated very comprehensively by Koenig (2008) in Figures 1 and 2 below.

Figure 1 a and b Older relationship between religion and spirituality
In figure 1(a) spirituality is seen as a core element of religiousness. The outer perimeter of the circle represents those who are superficially religious. Both of these are distinct from those who are secular, i.e. neither religious nor spiritual. All contribute to meaning, purpose and so on, as have an effect on emotional states and behaviour. In this model, spiritual persons can be compared with less spiritual people, and each can be...
compared to those who are secular. This model also allows examination of the effect of these constructs on anxiety, depression and so on, since they are distinct.

Figure 1 (b) shows a shift that represents a more recent understanding in that spirituality is now broader than religion and includes those from diverse religious groups and from none. Here we can see the emergence of a spiritual but not religious group while the secular group is still distinct. How the new ‘spiritual but not religious’ group is defined is unclear as the grounding in religiousness (See Fig. 1a) has been erased. Despite the absence of a clear definition, this model, in theory, still allows for comparisons between the three groups, religious, spiritual but not religious, and secular and also points to the possibility of examining the impact of these on mental health.

Figure 2 a and b Modern relationship between religion and spirituality
Figure 2 points to a new way of conceptualizing religiousness and spirituality and their relationship to each other and to other attributes such as purpose, meaning and so on.

Ask the question to most people in the Western world today ‘Are you religious’, and they will usually say that they are spiritual but not religious. Occasionally, when questioned specifically, they will tell you that they also attend church and engage in personal religious
activity such as prayer, fasting and so on but for most there is no connection to formal religious practices (Figure 2a).

Figure 2 (b) represents the conceptualization of spirituality, religiousness and secularism. Here spirituality is increasingly equated with personal wellbeing. So feelings of happiness and contentment are viewed equated with spirituality. This creates significant methodological problems in research examining the contribution of spirituality to mental health (see below).

The models above, point to four possible groupings between religiousness and spirituality shown in Table 1

Table 1 Classification of spiritual, religious and secular persons

<table>
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<th>Classification</th>
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<tr>
<td>1. Spiritual and religious – this classification represent the traditional view of the relationship of one to the other.</td>
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<tr>
<td>2. Spiritual but not religious – this is the newest group.</td>
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<tr>
<td>3. Neither religious nor spiritual – this is the secular group.</td>
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<td>4. Religious but not spiritual – this group has received little scientific attention</td>
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The group that are spiritual and religious conform to the traditional view of the relationship between these attributes. The person engages in religious practices and adheres to beliefs and rituals associated with the specific tradition as well as engaging in spiritual
activities such as meditating, fasting and reading illuminating texts, sacred and secular.

Spiritual and religiousness in this group are hand in glove and each enriches the other.

The group described as spiritual but not religious tend to view religiousness in a negative light, to be more independent of others, to hold ‘new age’ beliefs and to have mystical experiences (Zinnbauer et al 1997). They view spirituality and religion as non-overlapping constructs and these differences are shown in Table 2.

Table 2 Religion vz spirituality

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<tr>
<td>Authoritarian</td>
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<tr>
<td>Denominational</td>
<td>Personal</td>
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<tr>
<td>Linked to community</td>
<td>Autonomous</td>
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<tr>
<td>Ritualistic</td>
<td>Not hide-bound</td>
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<tr>
<td>Stipulates behaviours and rituals</td>
<td>Morality individualized</td>
</tr>
<tr>
<td>Personal God or Supernatural</td>
<td>Supernatural not necessary</td>
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<tr>
<td>Beliefs</td>
<td>Experiential</td>
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The third group in Table 1 above, those who are secular, are not much studied and if the model shown in Figure 2 (b) is applied above are likely to become extinct since feelings and mood states will be equated with spirituality also and thus experienced by everybody as part
of the day to day existence. The merging of the secular into the spiritual group is one which secularists may wish to eschew.

The fourth group, religious but not spiritual have not received any attention nor are they mentioned in the scientific literature specifically although they might conform to the group described by Allport and Ross (1967) as showing an extrinsic religious orientation i.e. engaging in the practice of religion but not in its spirit and not internalizing its message. They may be motivated by appearances and gain rather than by the inherent value of faith. Allport and Ross (1967) distinguished this group from those of intrinsic orientation who tried to assimilate the codes of their faith and to incorporate them into their person conduct. Unfortunately this group is often identified by the general public as ‘religious’ as if their practice was dry and arid, based on convention and habit rather than on any deeper perspective. This unhelpfully pits religiousness (bad) against spirituality (good) as has been demonstrated by Zinnbauer et al (1997) above.

That these groups are more than the imaginings of anthropologists is exemplified by a study (King et al 2006) which found that 17.7 per cent identified themselves as neither religious nor spiritual, 13.1 per cent described themselves as spiritual but not religious while 69.2 per cent described themselves as religious and spiritual. Interestingly nobody described themselves as religious but not spiritual.

That the construct known as spirituality is heterogeneous and means different things to different people is apparent from a study by Bibby (1995) in which Canadian adults were interviewed and 52 per cent expressed their spiritual needs in conventional religious terms such as belief in God, attending church and so on, while 48 per cent expressed these in more abstract terms, e.g. wholeness, reflection etc.
In religious and theological circles there is an understandable tendency to equate spirituality with religiousness or at least, with the sacred. This must now be seen as an oversimplification.

What is spirituality, what is religiousness?

Concerns about these constructs, particularly spirituality, have been articulated by Koenig (2008), who demonstrates the disparity and, at times vagueness, in the various definitions of spirituality in the scientific literature.

Religiousness is relatively easily defined but mainly encompasses

1. adherence to a set of beliefs, practices and rituals
2. that are related to the sacred and
3. to a particular tradition
4. for many they encompass belief in a personal God although it is accepted that the Buddhist tradition does not necessarily imply belief in God.

The sacred is defined as ‘that which relates to the numinous (mystical, supernatural) or God, and in Eastern religious traditions, to Ultimate Truth or Reality. Religion may also involve beliefs about spirits, angels, or demons’ (Koenig 2009).

By contrast spirituality is more difficult to define and several definitions exist.

One that is widely accepted is that of Ellison (1983), which says that

[s]pirituality is universal, yet unique to every person… (spirituality) enables and motivates us to search for meaning and purpose in life. It is the spirit which
synthesises the total personality and provides some sense of energizing direction and order. The spiritual dimension does not exist in isolation from the psyche and the soma. It affects and is affected by our physical state, feelings, thoughts and relationships.

This definition is difficult to understand and it is cumbersome without adding clarity. It presents a very broad and rhetorical description.

A more easily understood one, is that of Hill et al (2000) which defines spirituality as:

The feelings, thoughts, experiences and behaviours that arise from a search for the sacred. The term ‘search’ refers to attempts to identify, articulate, maintain or transform. The term ‘sacred’ refers to a divine being, divine object, Ultimate reality or Ultimate Truth as perceived by the individual.

This clearly places spirituality in the supernatural or sacred arena and is akin to that of the traditional view of spirituality.

Another definition by Cook (2004) says that:

Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately ‘inner’, immanent and personal, within the self and others, and/or as relationship with that which is wholly ‘other’, transcendent
and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values.

This definition suggests the universality of spirituality in that it is present in everybody as part of the experience of being human. There is also a transcendent element that is concerned with values and meaning.

The World Health Organization Quality of Life Assessment – spiritual, religious and personal beliefs (WHOQOL–SRPB) questionnaire (1998) does not directly define spirituality but in the instructions to the questionnaire it has defined spirituality very broadly indeed.

The following questions ask about your spiritual, personal or religious beliefs. These questions are designed to be applicable to people coming from many different cultures and holding a variety of spiritual, religious or personal beliefs.....Alternatively you may have no belief in a higher, spiritual entity but you may have strong personal beliefs or followings such as beliefs in a scientific theory, a personal way of life.....While some of these questions will use words such as spirituality, please answer them in terms of your own personal belief system, whether it be religious, spiritual or personal.

This definition is clearly an attempt to make spirituality ‘whatever you want’, catch-all ranging from the recognizably religious to a personal theory such as, for example, life on Mars or a belief in the value of skin-diving. It also encompasses within its domain feelings of
wellbeing and harmony. By broadening the boundaries it includes not simply religious or broadly sacred experiences but also aspects of mood and wellbeing (see Figure 2 above).

A more focussed but complex definition of spirituality has been developed by King and Koenig (2009) that encapsulated four domains as follows:

1. Belief
   An assent to or conviction about a domain or existence that goes beyond the material world. This includes all manner of religious or other beliefs that are not based on materialism.

2. Practice
   Spiritual or religious practice at this level occurs without conscious awareness of, or relationship to, the spiritual realm addressed. Although it involves exercises of imagination and desire such as contemplation, prayer, reading or reflection, the self is not moved by any direct experience of relationship with or connection to the other.

3. Awareness
   There is an awareness of being moved intellectually and/or emotionally. It includes contemplation, prayer, meditation or reflection when there is conscious awareness of, or response to, this dimension.

4. Experience
   A discrete experience which may include diffusion of the mind, loss of ego boundaries and a change in orientation from self towards or beyond the material world. The experience usually comes unbidden but may follow a period of reflection, meditation, stress or isolation. Ecstatic experiences are of this type, but experience may be much less intense and more prolonged.
A further definition by La Pierre (1994) described the characteristic of spirituality as follows:

A search for meaning in life

An encounter with transcendence

A sense of community

A search for the ultimate truth or highest value

Respect and appreciation for the mystery of creation

Personal transformation

This, like the definition by Hill et al (2000), is much more traditionally religious and trained on the transcendent.

**Is Separating Religiousness and Spirituality Important?**

Some may believe that questioning the overlap or separation between religion and spirituality is an exercise in hair splitting that is irrelevant in clinical and pastoral settings. This is only partially true. In arenas such as pastoral counselling, the difference is not relevant, since all counsellors, pastors and therapists should work within the framework of the person’s worldview whether it be a largely religious one, a spiritual one without any religious connotations, neither or a combination of both. All should be offered hope and meaning whatever their perspective.

However, if we wish to scientifically examine questions concerning the relationship between spirituality/religion and health then it becomes highly relevant.
The scientific study of religion and spirituality and their impact on peoples’ lives is relatively new and began in 1972, when George Comstock, an epidemiologist at Johns Hopkins Medical School, published a paper examining the link between mortality and church attendance in the general population. Spirituality and religion have traditionally being viewed as overlapping aspects of the one construct but as argued above this is no longer the case and both, increasingly, are seen as distinct constructs that inform peoples’ lives, although each probably in a different manner.

Notwithstanding this overlap between religiousness and spirituality in some definitions, equating spirituality with religiousness is likely to lead to a misunderstanding of their respective roles in building mental health resilience. Furthermore failure to recognize this distinction will not enable scientists to answer questions that are waiting to be asked and answered. These include:

Is religion beneficial or harmful to mental health?

Is spirituality beneficial or harmful to mental health?

Are both equally important?

Does each influence the same or different domains of mental health and its outcome?

How do they exert their benefits e.g. social support, prayer, meaning, hope, lifestyle, moral injunctions, church attendance and which emanate from religiousness, which from spirituality?

Other more specific questions relating to specific mental disorders could also be asked including ‘Do religious practices and spirituality contribute equally to recovery from depressive illness?’, ‘Are suicidal thoughts more or less common in those with spiritual
beliefs as compared to those who engage in religious practices?. ‘Do moral objections protect against suicide in mental illness?’ (Dervic et al 2011).

If there are no differences in the answers to these questions then the distinction is irrelevant. If, however, it were shown that, for example, religiousness benefited mental health through solidarity with like-minded individuals and that spirituality assisted in problem solving then clearly this would be relevant information that could help in identifying interventions tailored to individual attributes and strengths. If it were established that those who are religious are less likely to engage in suicidal behaviour than those who are spiritual, then this has important public health ramifications. Just as mental health professionals are interested in the role of social supports in assisting in recovery from illness so other attributes such as religiousness and spirituality are also important components of the individual to be examined.

It is also important to answer the question ‘how’? What is the mechanism by which religiousness assists people – is it through meaning and values, is it because of the lifestyle they live? Is it because of the friends and social supports that religion brings? What is the mechanism by which spirituality effects peoples’ emotional state – is it through enhancing self-esteem, is it by encouraging self-empowerment?

**Questionnaires that Measure Religiousness and/or Spirituality**

A number of questionnaires have been developed to measure spirituality and/or religiousness. Some of these measure both religiousness and spirituality in a single scale while others focus on one or the other. The researcher deciding on which scale to use will be challenged for three reasons:
1. The scale should clearly distinguish religiousness from spirituality and some questionnaires achieve this by means of separate subscales within the overall scale (Kendler 2003, King 2001), while others (Koenig 1997) have developed schedules that specifically measure one or other attribute.

2. Spirituality should be clearly defined within the scale.

3. Spirituality should not overlap with or be open to contamination from mood or general wellbeing. So questions relating to having a purpose in life or to optimism would inevitably be influenced by low mood and falsely result in the conclusion that the absence of spiritual beliefs was associated with low mood.

A number of scales will be outlined and critiqued in order to assist a researcher faced with a maze of schedules from which to choose. For further information on questionnaires measuring religiousness and spirituality the reader is directed to Koenig (2011), Koenig et al (2012) and the Fetzer Institute Report (2003).

One of the most widely used measures of spirituality/religiousness is the Functional Assessment of Chronic Illness – Spiritual Well-Being (FACIT-Sp) (Brady et al 1999). This has been used in many studies in cancer patients, and it is endorsed by the National Cancer Institute in the US as a measure of spirituality. There are many versions available and the original had 12 questions while the newest (FACIT-Sp-Ex) (Peterman et al 2002) has 23 that measure the role of faith/spirituality (e.g. I find strength in my faith or spiritual beliefs; I feel connected to a higher power or God) and the role of meaning/peace (My life lacks meaning and purpose, I feel loved) in those with chronic illnesses. This schedule does not distinguish spirituality from religiousness and many of the questions are related to emotional well-being although some are spiritual in content (I feel compassion for others in the difficulties they are...
in). However, studies purporting to use this as a spiritual/religious measure will clearly find a strong positive association with the emotional responses to physical illness.

The Spiritual Well-Being scale (Paloutzian and Ellison 1982) is one of the most widely used scales having been used in several hundred studies. It consists of 20 items, ten measuring religious wellbeing and ten existential wellbeing. Questions include ‘I feel life is a positive experience’, ‘I feel very fulfilled and satisfied with my life’. These questions are clearly identifying features of mental health and unless both domains are analysed separately there will be a strong association between the score on this scale and psychopathology. It is also questionable if the existential well-being questions are measuring anything uniquely spiritual rather than tapping into general measures of happiness.

The World Health Organization has developed the World Health Organization Quality of Life measure (WHOQOL) (WHOQOL Group 1998) with a subscale that measures spirituality, religion and personal beliefs (WHOQOL-SRPB). While describing eight dimensions (connectedness to a spiritual being/force, awe, meaning of life, wholeness/integration, spiritual strength, inner peace/serenity/harmony, hope/optimism and faith) that might capture religiousness and spirituality, the instructions for completing the questionnaire remove any meaning linked to religiousness and instead broaden the definition of spirituality beyond recognition to include personal beliefs and theories. This makes for the possibility that belief in aliens constitutes a spiritual dimension.

One of the results of this broad definition was shown in a study of relationship between quality of life and spiritual, religious and personal beliefs (Saxena and WHO QOL Group 2006). Using the WHO questionnaire and interviewing 5089 people from 18 countries, it found that in the analysis the measure of spirituality/religiousness explained 65 per cent of the variance in the quality of life score. A contribution of this size is implausible and is
almost certainly due to the broadness of the definition and the fact that feelings of wellbeing (such as hope and optimism) were included as measures of spirituality and also as measures of quality of life.

Another measure is the Multidimensional Measure of Religiousness/Spirituality (MMRS) (Fetzer Institute 1999/2003). This was the outcome of a report that presented 12 questionnaires measuring domains of religion/spirituality. The composite of these became the MMRS and a briefer version, with 38 selected items from the total formed the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS). This is widely used and it is gaining popularity due to the establishment of norms for the BMMRS in the general population. This makes it easy to compare results from research populations against national baseline scores. There are subscales measuring meaning, forgiveness and values. Questions include ‘The meaning of my life comes from feeling connected to other living things’, ‘It is easy for me to admit that I am wrong’, ‘I am able to make up pretty easily with friends who have hurt me in some way’.

The Daily Spiritual Experiences Scale (DSES) (Underwood and Teresi 2002) is extensively used as a measure of spirituality in mental and physical health research. It is a subscale of the Multidimensional Measure of Religiousness/Spirituality mentioned above (Fetzer Institute 1999). It consists of 16 items rated on 6 anchor points from ‘never or almost never’ to ‘many times a day’. Eight of the questions relate specifically to God although the instruction advises that God can be replaced by another that calls to mind the holy or the divine. The remaining eight questions are more general e.g. ‘I feel a selfless caring for others’, ‘I feel inner peace and harmony’, ‘I am spiritually touched by the beauty of creation’. This scale adopts a very broad definition of spirituality/religiousness, judging by the question content and many of the items are likely to score negatively in those with low mood.
A schedule that has separate measures of spirituality and religiousness was developed by King et al (2001). The Royal Free Interview for Spiritual and Religious Beliefs consists of 18 questions rated on a ten-point scale. The questionnaire begins by asking the person to indicate whether they are religious, spiritual, neither or both. Four of the subsequent questions relate to religiousness (public or private), ten to spirituality and three to both. The questions relating to spirituality are independent of mood.

Kendler (2003) developed a scale which reflects the multidimensional nature of religiousness and spirituality. It consisted of 78 items selected from various other questionnaires, which measured seven domains. These are general religiosity, social religiosity, involved God, forgiveness, God as judge, unvengefulness and thankfulness.

A specific measure of religiousness, which is the most simple to use, has been validated and meets the criteria delineated above is that by Koenig et al (1997). This is a five-item measure for use in health outcome studies (known as the Duke University Religion Index – DUREL) which consists of five questions. The first relates to church attendance or other religious meetings, the second to private religious activity such as prayer, meditation, bible study and the final three to the impact of these on one’s life and approach to life. Each question is rated on a five-point scale.

Is there Evidence that Religiousness and Spirituality have Different Influences?

This question has not received much attention due to the inclusion of religion and spirituality into a single measure in most studies. A few have separated them and the results while tentative suggest that there may be value in exploring the different contributions of spirituality and religiousness in greater depth than has hitherto been the case.
A Canadian study (Baetz et al 2004), arguably the largest of its kind, examined over seventy thousand adults as part of a multi-wave longitudinal study. Its aim was to identify the relationship between spiritual or religious self-perception and religious worship to depressive symptoms. Background confounders that might cloud the picture were controlled and these included socio-economic, demographic (e.g. age), and health variables. Those who attended church more frequently had significantly fewer depressive symptoms, while those who stated that spiritual or religious values were important to them, or perceived themselves to be spiritual or religious, but who were not involved in religious institutions, had higher levels of depressive symptoms. Clearly the relationship between spirituality and religiousness is complex, but the findings suggest that formal involvement in worship carries benefits that are not obviously evident amongst those with more diffuse attitudes (such as merely perceiving or stating themselves to be spiritual or religious).

King et al (2006) examined six ethnic groups in Britain. Comparing the combined religious/spiritual group with those who are neither, no difference in the prevalence of common mental disorders (CMDs) was found. However, when the spiritual groups who did not practice religion were compared with those who did engage in religious practice, CMDs were twice as common in the former.

A more recent study on suicidal behaviour (Rasic et al 2009) found that self-harm behaviour such as overdosing and cutting was lower in a group who self-identified as religious in comparison to those who identified as spiritual after controlling for social supports.

A study that highlights the complexity of the relationship between spirituality, religiousness and depression examined the contribution of these to a lifetime history of depression (Maselko et al 2009). Over 900 subjects were interviewed using standardized
measures of depression. Religiousness was established by inquiry about the frequency of attendance at religious services while spirituality was divided into existential and religious well-being using the Spiritual Well-being scale summarized in the previous section (Paloutzian and Ellison 1982). It found that regular religious attendance reduced the odds of having a depressive illness by 30 per cent. The two dimensions of spirituality had a more complex relationship with existential well-being reducing the odds of depression by 70 per cent, while religious well-being increased the odds. A problem with the study is that the existential well-being scale contains questions that may be tapping into general well-being so the association may be spurious. A number of other explanations may also account for the increased odds of depression in those with high religious-wellbeing.

More recently a study by King et al (2013) examined the responses of over 7403 subjects from the third National Psychiatric Morbidity Study conducted between October 2006 and December 2007 across England. Information on whether the respondents had a religious outlook on life, one that was spiritual but not religious or one that was neither was gathered using an adapted version of the Royal Free Interview for Spiritual and Religious Beliefs (King et al 2001). A battery of structured interviews to evaluate psychiatric disorders and substance misuse was also administered. The study found that people who had a spiritual understanding of life had worse mental health than those with an understanding that was neither religious nor spiritual. Those who were religious were broadly similar, in terms of prevalence of mental disorder and use of mental health treatments, to those who were neither religious nor spiritual after adjustment for potential confounders. However, they were significantly less likely to use, or be dependent on, drugs or alcohol. The study concluded that people who profess spiritual beliefs in the absence of a religious framework are more vulnerable to mental disorder. They suggested that one possible explanation is that they are engaged in an existential search that is driven by their emotional distress but recommended
that further qualitative and quantitative studies would assist in clarifying the nature of the association.

There is evidence that positive religious coping is prominent in those with long term mental illness, with large numbers spending a significant amount of time in prayer (Tepper et al 2001). For example, meditation and religious activity were identified as particularly helpful in a group with bipolar disorder (Russinova et al 2002). Of 406 with long term mental illness 80 per cent used religious coping, 61 per cent spend more than 50 per cent of time in religious coping e.g. prayer and large numbers reported religious activities as the most beneficial alternative health care intervention.

Conclusion

There are numerous questions with respect to the relationship between religiousness or spirituality and mental health variables that beg to be answered. This endeavour requires research of the highest quality. One of the fundamentals of this approach is that construing spirituality and religiousness as similar dimensions is an over simplification. Instead greater attention needs to be paid to conducting studies that investigate religiousness and spirituality as separate and complex entities, each clearly defined with respect to their role in emotions, behaviour and functioning. Provided this is the strategy, whether people self-define as religious, spiritual, neither or both becomes irrelevant since each construct can be evaluated independently. In addition the measure of spirituality must truly be tapping into a domain that is independent of mental well-being. The basic principles of epidemiological research can and should be applied to spirituality and religiousness so that the profound questions about meaning, purpose, God, the sacred, prayer, the supernatural and a myriad of related matters can be studied with confidence.
References


General Medical Council (2008), *Personal Beliefs and Medical Practice*, London: General Medical Council.


