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The Effects of Religion and Locus of Control on Perception of Mental Illness

Sedem Nunyuia Amedome[1] · Innocent Kwame Bedi[2]

Abstract

The study investigated the influence of religion and locus of control on perception of mental illness. Specifically, the study explored the relationship between religiosity and perception of mental illness, differences in perception by internals and externals, the effect of knowledge on perception of mental illness and the interactive effect of religiosity and locus of control on perception of mental illness. Data were collected from 200 participants in the Volta Region of Ghana. Three hypotheses were tested in the study using a battery of tests. It was observed that people with internal locus of control perceive mental patients positively than those with external locus of control. A significant interactive effect between religiosity and locus of control on perception of mental illness was observed. Religiosity significantly relates to perception of mental illness. The results and implications are discussed for further studies.

Keywords Perception · Religiosity · Mental illness · Locus of control · Mental health

Introduction

Background of the Study

The impact of religion on mental health has been debated for centuries. History shows that religious organizations were often the first to offer compassionate care to the vulnerable groups, including the medically ill, the elderly and the disabled. The first hospitals for patients with mental health problems established in the fourteenth century were church sponsored and priest managed (Alexander and Selesnick 1966).

Toward the end of the Middle Ages, religious scientists first suggested that biological mechanisms rather than supernatural powers were responsible for mental illness (Kroll 1973). The idea and approach of moral treatment of individuals with mental health problems actually originated from the religious people. Benefited from this approach, individuals with

✉ Sedem Nunyuia Amedome
   samedome@htu.edu.gh

   Innocent Kwame Bedi
   innocent.kwame.bedi@ut.ee

[1] Ho Technical University, P.O. Box HP217, Ho, Ghana

[2] Institute of Education, University of Tartu, Tartu, Estonia

mental health problems were treated much like normal persons (Taubes 1998). Hence, religion had played a significant role in shaping the form of mental health care.

However, the postulations of Freud and other mental health scholars concerning the neurotic influences of religion have had an enormous impact on the field of mental health in the twentieth century. Freud had been skeptical, if not antagonistic toward religion. He suggested that the less religious people were more mentally healthy (Ellis 1980, 1988). Wendell Watters, another well-known psychiatrist, also stated that religious beliefs were responsible for the development of low self-esteem, depression and even schizophrenia (Watters 1992).

In Ghana, a study done by Raja et al. (2007) suggested that Ghana is a 'religious country,' evidenced in the almost every one of the over 21 million people living in Ghana belonging to one form of religious group or the other. The arrival of white missionaries centuries ago, coupled with the guarantees of freedom of worship and the right to belong to any religious organization by the 1992 Ghanaian Constitution, has allowed the practice of several religions in Ghana. According to the report, there are predominantly three religions in Ghana, being Christianity, Islam and traditional religions (indigenous faith of Ghanaians before the introduction of Christianity). Christianity accounts for a majority of the population (70%) among which Catholicism also predominates. Next in numbers is Islam which is mostly practiced in the north.

Citing Appiah-Kubi and Boyce (2006), Raja et al. (2007) contend that traditional, faith-based and herbal healers who treat mental illness are practically everywhere in the country and that these traditional (orthodox) and faith healers cater for the largest proportion of the mentally ill in Ghana and may have contributed to the widespread belief that mental illness is a spiritual curse. They further indicated that life stories and individual files of mentally ill persons of Basic Needs programmes in Northern Ghana and Accra frequently indicate that they have been to either a spiritualist or traditional healer or both before.

Problem Statement

A World Health Organization report (2006) mentioned that around 98% of mentally ill people in Ghana opt to attend prayer camps or traditional healing shrines in order to get better even though many go untreated. The pastors and 'healers' at these prayer camps shackle and chain their patients in order to control their behavior. Patients with severe depression or schizophrenia are often beaten and starved by 'healers' to try to get rid of supposed 'evil spirits.'

In spite of the failure of these traditional healers to secure the healing of these mentally ill patients, the patronage of these centers ever keeps on increasing. It is therefore important that a study be conducted to discover the view held by people as regards the operations of these prayer camps and shrines.

Secondly, investigations into the activities of mentally ill individuals in prayer camps focused on the human rights issues of the patient and influence of religion in deciding the choice of treatment center. Also, little is known about the locus of control and perception of the caregivers and the 'healers' regarding mental illness. This study would thus bring this to the fore.

Finally, one other reason that justifies the conduct of this study is the situation of the study. The participants are relatives of mentally ill patients who are in the prayer camps as caregivers and the 'healers' at the camps. This choice of subjects would thus record their true perception/attitude toward health seeking of the mentally ill.

Aims and Objectives of the Study

The main objective of the study is to investigate the locus of control and perception of people about mental illnesses.

Specific objectives:

1. To investigate the extent to which people's locus of control influences perception of mental illness.
2. To examine the relationship between religiosity and perception of mental illness.

Statement of Hypotheses

1. Internals are more likely to perceive mental patients positively than externals.
2. There will be a significant positive relationship between religiosity and perception of mental illness.
3. Locus of control and religiosity will interact to significantly influence perception of mental patients.

Literature Review

Theoretical Literature

Within the framework of psychology, mental disorder or illness is seen as a psychological or behavioral pattern generally associated with subjective distress or disability that occurs in an individual, and which is not a part of normal development or culture. The recognition and understanding of mental health conditions have changed overtime across cultures, and there are still variations in the definition, assessment and classification of mental disorders, despite the availability of standard guideline criteria (Insel and Wang 2010). They stressed that, in biological psychiatry, mental disorders are conceptualized as disorders of brain circuits likely caused by development processes shaped by a complex interplay of genetics and experience.

There are many categories of mental disorder and many different facets of human behavior and personality that can become disordered (Gazzaniga and Heatherton; United States Department of Health and Human Services 1999; NIMH 2005). The disorders may include anxiety disorders such as phobias, generalized anxiety disorder, social anxiety disorder, panic disorder, agoraphobia, obsessive–compulsive disorder and posttraumatic stress disorder. In addition, some disorders are classified as mood disorders because they affect our emotions or mood. Typical examples include major depression and bipolar depression (Akiskal and Benazzi 2006).

The clinical literature uses two main classification systems to define mental illness. The first system, described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), is most widely accepted by the clinical community. DSM is a multi-axial classification system that defines a mental disorder as 'a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual, and is associated with present distress or disability, or with a significant increased risk of suffering.' DSM groups disorders by symptom clusters and differentiates between normality and psychopathology on the basis of the duration and severity of symptoms. For the purpose of reimbursement coding, clinicians also use the

International Classification of Diseases and Related Health Problems (ICD). ICD is 'cross walked' with DSM, meaning that DSM diagnoses are included in ICD (Cooper 1995).

The second classification system conceptualizes mental illnesses as 'brain disorders' and is based on the hypothesis that disruptions in brain function lead to mental illness. Rather than relying on descriptive criteria such as those in *DSM*, bio-psychiatrists classify mental disorders on the basis of heritability, biochemical markers and anatomical lesions (Heyada 1996). The appropriateness of biological psychiatry's classification system continues to be actively debated. Most clinicians agree that the use of purely biological criteria is too limiting, because no single gene or underlying brain lesion has been found for any disorder except Alzheimer's disease (McLaren 1992).

Empirical Literature

The Link Between Religion and Perception of Mental Illness

Mental illness has been conceptualized as a manifestation of a behavioral, psychological or biological dysfunction in the individual (Sadock and Sadock 2003). Ultimately, they define mental illness as a behavior or psychological syndrome that is clinically significant and which is related to distress or disability (Sadock and Sadock 2003).

It can be argued though that the term 'mental illness' has medical model implications and is perhaps not as ideologically neutral as the term 'psychological disorder'(Million et al. 2004). Furthermore, mental illness traditionally connotes severe forms of psychological disorder, such as schizophrenia or mania, and does not encompass less severe psychological disorders such as adjustment disorders, anxiety disorders, mild depression and posttraumatic stress disorders (Million et al. 2004). However, Jorm (2000) argues that individuals, who are not in the mental health field, often cannot recognize specific mental disorders or different forms of psychological distress. It has been argued that the understanding of the term 'mental illness' among laypersons encompasses both severe mental disorders and the less severe psychological disorders.

Mental illness is said to be socially constructed and socially defined; that is, different professions, communities, societies and cultures have very different ways of conceptualizing the nature and causes, determining what mental illness is and deciding what interventions are appropriate. All individuals are influenced in their development by various cultural and personal dimensions of identity (Arredondo and Toporek 2004). By implication, the values and beliefs which individuals acquire such as religious beliefs and beliefs about control of reinforcement (i.e., locus of control) will significantly influence perception of mental illness.

In a study involving eight female counselors age ranging from 29 to 52 years, it was observed that one's religious and cultural beliefs play an imperative role in an individual's perception of mental illness. In addition, the values and beliefs held by a specific community were found to significantly influence an individual's choice of treatment for a mental illness (Khan 2009).

A relatively significant body of research has shown that members of a population that regard themselves as religious have less psychological distress, more life satisfaction and greater achievement of life goals (Corrigan et al. 2003). Recent scientific research has indicated that affirming belief in God may contribute to physical and mental health and that when people call upon faith, they activate pathways for self-healing (Syed 2003; Daaleman

2004). Religious practices, as a means of coping with persistent mental illness, appear to be quite prevalent (Tepper et al. 2001). Mental health service providers also need to be aware of the integral role that religious practices and beliefs may play in one's ability to cope with or overcome their mental illness (Tepper et al. 2001).

In a study aimed at examining the prevalence of religious coping among psychiatric patients (Tepper et al. 2001), it was found that 92% of patients reported using a religious activity to help them cope with their symptoms and frustrations or difficulties. Koenig et al. (1998) also found that more than half of the patients interviewed, for a similar study, reported using a religious belief or activity to cope with mental illness. Religious faith may provide one with a sense of hope and positive thinking and may result in a greater motivation to achieve and maintain a healthy mental state (Koenig et al. 1998).

The Link Between Locus of Control and Perception of Mental Illness

Little research has been done to apply these concepts of sense of control or locus of control to persons with mental illness and how a sense of control over the everyday features of their lives may be related to some other key concepts in mental health services, such as mandated treatment and treatment compliance. Some indication of why the connection between mental illness and locus of control may be important comes from the work of Lidz et al. (1997). In interviews with persons with mental illness who had been involuntarily hospitalized, many patients reported not feeling coerced despite having been brought to hospital emergency rooms by police or forcibly by family members (Hoge et al. 1997). Subsequent interviews with people evaluated for civil commitment in emergency rooms, with clinicians and with family members reinforced a difference between 'objective coercion' and 'subjective coercion,' i.e., what an external observer might assess as a coercive situation, where physical force was used, but was not one reported as producing subjective reports of perceived coercion (Lidz et al. 1998).

Methodology

Population and Participants

The population used for the study was people who are associated with one form of religion or the other in the Volta Region of Ghana. The region was selected for consideration as a result of the increasing number of these prayer camps for mental illness patients and the high patronage by relatives of mentally ill individuals who are sent there for spiritual and physical healing of these conditions.

Sampling and Sampling Characteristics

A convenient sampling technique was used to select respondents from the main religious grouping in the region. Also convenient sampling was used to select the participants for the study. This is because the participants had to agree to participate in the study before questionnaires were administered to them. In all, 200 respondents agreed to participate. From the table below, the characteristics of the respondents show that there are 100 males and 100 females. Regarding age distributions, 75% of the participants were aged between 18 and 35 years and the rest aged between 36 and 60 years. The data also revealed that

there were 50% of the participants who have high level of education (polytechnic and above) and the rest with student, trading, clerical duties, tradesmen/women, teaching, driving and farming. The results show that 27.5% of the participants were students and 3.5% are engaged. See Table 5 in 'Appendix.'

Design of the Study

A cross-sectional survey design was adopted for the study. The design was considered appropriate in that the sample elements are of varying characteristics (age, sex, occupation, etc.). Also, questionnaires were used to gather evidence on the variable investigated in the study.

Materials/Scales

Participants completed a survey packet that included a demographic questionnaire and instruments measuring perception of mental illness, locus of control and religiosity. A description of the various instruments and their reliability coefficients are presented below:

- *Religiosity* The Santa Clara Strength of Religious Faith Questionnaire (SCORF) was adapted for the study. The scale was developed to focus on strength of religious faith without regard to denominations. It is measured using ten items that are responded on a four-point scale (Plante et al. 1999). The scale is highly reliable, with a Cronbach's alpha ranging from .90 to .96 (Plante et al. 1999). The present study recorded an internal consistency coefficient of .89. The scale measures religiosity at two levels— low and high levels of religiosity. In scoring, total scores ranging from 10 to 30 are regarded as having low religiosity and scores ranging from 31 to 40 are considered as scoring high on the religiosity scale.
- *Perception of mental illness scale* The scale consists of 26 items measured on a five-point Likert response ranging from 1 (strongly agree) to 5 (strongly disagree). In scoring the questionnaire, the sum of the responses was computed to represent the perception of the respondents on mental illness.
- *Multidimensional health locus of control scale* It is an 18-item, self-report questionnaire made up of five discrete subscales designed to measure health locus of control. The subscales measure expectancies in five general areas: Internal Health Locus of Control, Powerful Others Health Locus of Control, and Chance Health Locus of Control, Other People Health Locus of Control, Doctor's Health Locus of Control. The items are scored on a six-point Likert response scale ranging from 1 (strongly disagree) to 6 (strongly agree). Scores on the MHLC are calculated by summing respective items for a total scale score (i.e., where 1 = "strongly disagree" and 6 = "strongly agree"). The sum of the following items represents the score on internal locus of control: 1, 6, 8, 12, 13, 17, and the sum of the responses of following items: 3, 5, 7, 10, 14 and 18 represents the scores on the external locus of control. The scale reported a Cronbach's coefficient which ranges from .60 to .75 (Wallston et al. 1978).
- *Demographic questionnaire* The demographic questionnaire requested information on the participant's sex, level of education, age, occupation and sex. Also the section solicited information on the religious affiliation and marital status of participants.

Pilot Study

Prior to the main survey, the questionnaire was piloted in some selected communities in the Ho Municipality of the Volta Region. Participants were selected at their place of worship to respond to the items. Thirty participants were sampled for the pilot study. It was observed that participants understood the items on the scale and also the scales were found to be reliable given the obtained alpha values. The reliability values of the scales used in the study are detailed in Table 6 in 'Appendix.'

Ethical Considerations

The study used questionnaire to obtain demographic information, data on the perception of caregivers and the traditional healers at the various prayer camps randomly selected. As result, in line with the American Psychological Association (APA 2002), certain ethical considerations were observed regarding the use of human subjects for research. Specifically, Standard 3.10 of APA which stipulates that informed consent must be sought from the participants and that the participants should be well briefed on the consequences of taking part in the study and the right to withdraw at any point in time was observed strictly. This was strictly observed with participants signing the consent form attached to the questionnaire.

Finally, participants were assured of utmost confidentiality of information and this was demonstrated with the questionnaire not having any identifiable label. Participants were also informed that the information provided was meant for academic work only.

Results

The analysis in this study was in two stages. The first stage involved computation of means, standard deviation scores and reliability test of the study variables while the second stage involved test of hypotheses. Reliability test was conducted to determine the psychometric properties of the study variables. The test results revealed acceptable Cronbach's alpha values for psychological analysis. Table 1 presents a summary of means, standard deviation scores and alpha values of the variables.

Test of the Effect of Locus of Control on Perception of Mental Illness

Internals are more likely to perceive mental patients positively than externals.

Table 1 Summary of means, standard deviation scores and alpha values of study variables

Variables	M	SD	Alpha (α)
Religiosity	34.915	4.282	.90
Health locus of control	62.260	15.294	.86
Perception	71.139	11.594	.84

Total number of respondents ($N = 200$)

The two-way ANOVAs test was appropriate to test this hypothesis because it involves two independent variables (e.g., internal and external locus of control) and a single dependent variable (perception—positive). Thus, a univariate analysis was conducted to determine the amount of variance in perception (positive) contributed by the independent variables. The variance or effect size of the independent variables was determined using the partial eta-squared values. The eta-squared values tell the strength of the association between variables.

As shown in Table 2, the prediction that internals are more likely to perceive mental illness positively than externals was supported as internals significantly influence perception [$F_{(17,62)}$ = 4.62, $p < .05$, partial eta squared = .74] than externals [$F_{(15, 62)}$ = 1.27, $p > .05$, partial eta squared = .41]. This means that internals rather than externals perceive mental illness positively in this study. The effect size of the variables showed that internal locus of control had the greatest effect on perception than externals.

Religiosity and Perception of Mental Illness

There will be a significant positive relationship between religiosity and perception of mental illness.

The relationship between religiosity and perception of mental illness was investigated using Pearson product-moment correlation coefficient. The result revealed there was a small significant positive correlation between the two variables [$r = .18$, $n = 200$, $p < .05$] implying that high levels of religiosity are associated with high levels of perception of mental illness (Table 3).

Religiosity, Locus of Control and Perception of Mental Illness

The prediction that religiosity will interact with locus of control to significantly influence perception of mental illness was supported [$F_{(74, 192)}$ = 4.039, $p < .001$]. This means that one's perception of mental illness is influenced by the combined effect of religiosity and locus of control (Table 4).

Table 2 Two-way ANOVAs test of the effect of locus of control on perception of mental illness

Source	Sum of squares	df	Mean square	F	Sig.	Partial eta squared
Internals	862.536	17	50.737	4.62	.000	.74
Externals	208.525	15	13.902	1.27	.287	.41
Error	296.256	27	10.972			
Total	212,206.000	62				

R squared .999 (adjusted R squared .997)

Perception level = positive perception

Table 3 Correlations between religiosity and perception of mental illness

	Religiosity	Perception of mental illness
Religiosity		.18[a]
Perception of mental illness	.18[a]	
Total	200	200

[a]Correlation is significant at .05 (2-tailed)

Table 4 Summary of two-way ANOVA of the interactive effect of religiosity and locus of control on perception of mental illness

Source	SS	df	MS	F	Sig.
Religiosity	4115.911	15	274.394	6.457	.000
Locus of control	6745.469	39	172.961	4.070	.000
Religiosity × control	10,813.947	63	171.650	4.039	.000
Error	3144.690	74	42.496		
Total	24,819.917	192			

Discussion

The study investigated the influence of locus of control and religiosity on perception of mental illness. To achieve the study objective, community perception of mental illness was explored. In addition, the study examined the relationship between religiosity and perception of mental illness, and finally the interactive effect of religiosity and locus of control on perception of mental illness.

The Effect of Locus of Control on Perception of Mental Illness

The study postulated that 'internals are more likely to perceive mental illness positively than externals.' As expected, this prediction was supported by the results of the present study. This means that the locus of control of a person was important in determining the person's perception of mental illness.

It has been reported that sense of control is vital and therefore contributes in a variety of ways to our mental and physical well-being which are essential elements of quality life (Abeles 1991). Generally, internals have been found to have a strong sense of control than externals. Thus, internals have control over experience of reinforcement of value as meaningful or influential to them because they believe that they have control over reinforcement, and to increase or decrease it, they change their behavior. Individuals with external locus of control are less likely to change their behavior because they do not believe that changing their behavior would have an effect on the reinforcement (Baumeister et al. 1998). The result obtained in this study suggests that indeed internals rather than externals are more likely to perceive mental patients positively. This indicates that sense of control (i.e., internals) significantly influences positive perception of mental illness.

Relationship Between Religiosity and Perception of Mental Illness

The study hypothesized that 'there will be a significant positive relationship between religiosity and perception of mental illness.' True to the expectation of the study, this prediction was supported. This means that the increase or decrease in religiosity was associated significantly with perception of mental illness.

The finding posted in the present study supports what has been reported in previous studies. For instance, when in crisis, religious people first turn to their clergy or congregation and feel less stigma in the process (Chalfant et al. 1990 as cited in [Peters and Clay 1999]). In addition, other studies observed that when in trouble 42% of people go to their clergy first, 29% go to non-psychiatric physicians and 31% visit a psychiatrist, psychologist or marriage counselor (Gurin et al. 1960 as cited in [Peters and Clay 1999]).

The Interactive Effect of Religiosity and Locus of Control on Perception of Mental Illness

The study hypothesized that 'religiosity will interact with locus of control to significantly influence perception of mental illness.' This prediction was supported in the study. This implies that our perceptions are influence by several factors and those accurate perceptions of some events or situations require two or more factors combined. Specifically, it can be said based on the result that being religious alone is not enough to influence perception but the sense of control of the person also has a role to play (i.e., locus of control).

This relates to the literature that individuals with internal locus of control and who are religious will seek first the consent of the clergy with mental health problems (Chalfant et al. 1990 as cited in [Peters and Clay 1999]). In addition, internals have been found to have a strong sense of control than externals because they have control over experience of reinforcement of value as meaningful or influential to them (Baumeister et al. 1998).

Conclusion

The study examined the influence of locus of control on perception of mental illness and the moderating effects of religiosity. It was observed that internals were found to have positive perception of mental illness than externals.

The present study is not without limitation despite the significant results posted. The study utilized a design which was informed by the objectives of the study. However, this design did not ensure the establishment of causal relationship between the variables tested in the study. This therefore makes it difficult to draw causal inferences in the results obtained in the study.

The results in the study have both theoretical and practical relevance. Theoretically, the result strengthens literature in the area of mental illness. This is because the interactive effect of religiosity and locus of control on perception has a significant effect on choice of treatment and perception of mental patients.

Practically, it provides practitioners, non-governmental organizations and other individuals who are into mental health a way to deal with negative attitudes toward the mentally ill. Specifically, practitioners are required to educate the general public, caregivers and the mentally ill on the scientific causes of mental illness as this will help people make an informed decision regarding treatment-seeking behaviors as well as choice of treatment center.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Appendix

See Tables 5 and 6.

Table 5 Sample characteristics

Variable	Frequency	Percent
Sex		
Male	100	50.0
Female	100	50.0
Age		
18–35 years	150	75.0
36–60 years	50	25.0
High level of education	100	50.0
Lower level of education	100	50.0
Occupation		
Student	55	27.5
Trading/business	30	15.0
Clerical duties	12	6.0
Tradesman/woman	13	6.5
Teaching	7	3.5
Farming	10	5.0
Driver	2	1.0
Other	19	9.5
No response	52	26.0
Religion		
Christian	100	50.0
Islam	50	25.0
Traditional	50	25.0
N	200	100

Table 6 Summary of scales and reliability values

Scales	No. of items	Alpha values
Religiosity	10	.70
Perception	26	.80
Locus of control	18	.75

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