Roles of Religious and Spiritual Advisors Among Adults in Singapore With Mental Illnesses

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Objective: **Information is limited concerning the role of religious and spiritual advisors in providing help to people with mental illnesses in Singapore. This study examined that role, as well as the satisfaction with and the perceived effectiveness of the services provided, among people with mental health problems.** ***Methods:*** **Data were collected as part of a nationally representative household survey of residents 18 years and older in Singapore. The Composite International Diagnostic Interview, version 3.0, was used to diagnose mental illness as well as to collect information about the mental health services respondents had sought.** ***Results:*** **A total of 6,616 respondents completed the survey; in the overall sample, 1.5% reported seeking help from religious or spiritual advisors. This rate increased to 6.6% among those with at least one mental illness, with the prevalence being higher among respondents with lifetime dysthymia, generalized anxiety disorder, or bipolar disorder. Sociodemographic correlates associated with a lower likelihood of consultation with a religious or spiritual advisor included reporting "other" race-ethnicity as well as faith in Buddhism, Hinduism, or Islam. Most respondents who sought help from a religious or spiritual advisor in the last 12 months were satisfied with the help they received, and about half reported it to be very useful.** ***Conclusions:*** **Religious and spiritual advisors are an important source of help for people with mental illness, and a majority of respondents with a mental illness were satisfied with the support they received from these sources. (*Psychiatric Services* 64:1150–1156, 2013; doi: 10.1176/appi.ps.201200533)**

The World Health Organization (WHO) has reported that approximately 450 million people worldwide suffer from a mental or substance use disorder (1), and the prevalence is expected to increase with an aging population, resulting in increased burden, disability, and economic hardship. Although mental illnesses are not uncommon, many people do not seek help despite the availability of various effective services and treatments. The decision to seek help for mental illness may be influenced by several factors, including socioeconomic factors (2), cultural and contextual influences (3), social influences (4), and demographic characteristics (5). Health beliefs, including attitudes, values, and knowledge relating to mental health and appropriate services, will also influence a person's perception of the need for and use of such services (6).

Use of the general medical care system for treatment of mental health problems has been well documented in the literature. There has also been extensive research about the relationship between religion, well-being, and mental health, including how religious beliefs and practices help with coping, in providing support and promoting hope and optimism among people with mental health problems (7–10). However, less is known about the specific role of religious and spiritual advisors, including church ministers, priests, or monks, in helping with psychological problems (11).

The debate about whether to incorporate religious and spiritual approaches into treatment for mental illness has received increased attention in recent years, with differing views on whether a religious or spiritual approach is beneficial or problematic for individuals with a mental illness (12). Relatively strong correlations between religious participation and positive outcomes have emerged in the literature, including lower rates of depression, anxiety disorder, smoking, and substance abuse (13–15). Religious beliefs may also affect medical decision making, generate beliefs that

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conflict with medical care, induce spiritual struggles that create stress and impair health outcomes, and interfere with disease detection and treatment compliance (8). Most of the studies conducted in Asia have focused on help-seeking behavior among people with mental health problems (16–19) or the role of religion and spirituality in coping with mental health problems (20,21).

Singapore is situated at the southern tip of the Malaysian peninsula and has a population of 3.8 million citizens and permanent residents (22) who are largely from three ethnic backgrounds: Chinese, Malay, and Indian. The 2010 Census found that 33.3% of the resident population over age 15 were Buddhists (33.3%), whereas 10.9% were Taoists. The other main religions in Singapore were reported as Christianity (18.3%), Islam (14.7%), and Hinduism (5.1%), and the census indicated that 17.0% of the population did not declare a religious affiliation (22).

The recent Singapore Mental Health Study (SMHS) was conducted among Singapore's adult residents and aimed to determine the prevalence of mental disorders within this population (23). Subsequently, the study explored help-seeking behavior and the use of mental health services among those with a mental illness. This article discusses these findings from the SMHS and aims to establish the prevalence of and factors relating to the use of religious and spiritual advisors for help with mental illnesses and determine the satisfaction with and perceived effectiveness of these services.

Methods

Participants and procedure

The methods undertaken as part of the SMHS have been described elsewhere (24). Briefly, the SMHS was a population-based epidemiological study conducted between December 2009 and December 2010, after approval from the relevant institutional review boards. Respondents were randomly selected to participate via an administrative database. A total of 6,616 people completed the face-to-face interview, yielding an overall response rate of 75.9%. Respondents were Singapore citizens and permanent residents who were age 18 and older.

On receiving residents' agreement to participate, we obtained written informed consent from all participants; for those under age 21, we also obtained consent from a legally acceptable representative. Respondents were interviewed in their homes or at a location of their choice and were asked to complete a series of interviewer-administered instruments in English or Mandarin, via computer-assisted personal interview, or in Bahasa Melayu, via a paper-and-pencil interview. Professionally trained interviewers from an external survey firm conducted the interviews after undergoing training and supervision by research staff at the Institute of Mental Health, Singapore. Quality assurance processes were also implemented to ensure high-quality data, whereby 20% of each interviewer's cases were subjected to detailed verification in order to detect any falsification.

Measures

A modified version of the Composite International Diagnostic Interview (CIDI 3.0) (25) was used for the SMHS and included diagnostic modules on major depressive disorder, bipolar disorder, generalized anxiety disorder, obsessive-compulsive disorder, and alcohol use disorder, as well as a module on service use. The CIDI 3.0 is a fully structured diagnostic instrument that assesses lifetime and recent prevalence of disorders using the definitions and criteria of the *DSM-IV* and the *ICD-10*. For the purposes of this study, only *DSM-IV* criteria were used to generate a diagnosis, with organic exclusions and diagnostic hierarchy rules applied.

For this analysis, the CIDI captured information within the services module relating to consultation with religious or spiritual advisors for help concerning mental illnesses. Respondents were asked, "Did you ever in your lifetime go to see any of the professionals on this list for problems with your emotions, nerves, mental health, or your use of alcohol or drugs?" Participants who answered yes were presented with the following list of service providers: psychiatrist; general practitioner or family physician; any other medical doctor, such as a cardiologist, urologist, or gynecologist; psychologist; social worker; youth aid worker; child welfare officer; school counselor or teacher; counselor other than a school counselor; any other mental health professional, such as a psychotherapist or psychiatric nurse; general nurse; occupational therapist or other health professional; religious or spiritual advisor, such as a minister, priest, monk, or imam; or any other healer, such as a herbalist, homeopath, naturopath, chiropractor, spiritualist, or traditional healer. Subsequent questions asked respondents how satisfied they were with the help they received from the religious or spiritual advisors in the past 12 months and how helpful it was. Given the diversity of providers among the "other healers," we have omitted this group from this analysis, because our intention was to focus solely on the role of religious and spiritual advisors.

Sociodemographic information relating to age, gender, ethnicity, education, marital status, income, employment history, and so on was also collected from all respondents. Forward-translation methods were used to translate from English to Mandarin and Bahasa Melayu the questionnaires and measures that were not available in these languages.

Statistical analyses

To ensure that the survey findings were representative of the Singapore population and to adjust for oversampling and poststratification, the data were weighted according to age and ethnicity distributions between the survey sample and the Singapore resident population in 2007. Means and standard deviations were calculated for continuous variables, and frequencies and percentages were calculated for categorical variables. A multiple logistic regression model was used to generate odds ratios and 95% confidence intervals. Consultation with any religious or spiritual advisor was the main outcome variable, and age group, ethnicity, gender, marital status, education, employment, income, religion, and presence of mental

Table 1

Prevalence of lifetime and 12-month consultation of religious and spiritual advisors among 6,616 Singapore residents

Characteristic	Lifetime			Past 12 months		
	N	Weighted %	SE	N	Weighted %	SE
Overall sample	84	1.5	.22	20	.3	.09
Mental disorder						
Major depression	27	6.1	1.80	7	1.7	.72
Dysthymia	2	26.0	15.03	0	—	—
Bipolar	13	15.7	5.65	2	1.7	1.25
Generalized anxiety	11	20.0	7.30	2	1.4	1.03
Obsessive-compulsive	10	6.0	2.44	3	4.8	3.43
Alcohol abuse	9	4.5	2.06	1	1.1	1.11
Alcohol dependence	2	1.9	1.40	1	1.5	1.53
Any	50	6.6	1.29	10	2.0	.95

disorder were the predictor variables. Standard errors and significance tests were estimated via the Taylor series linearization method. Multivariate significance was evaluated with Wald chi square tests based on design-corrected coefficient variance–covariance matrices. Statistical significance was established at $p<.05$ with two-sided tests. All statistical analyses were carried out with SAS, version 9.2.

Results

Sample characteristics

A total of 6,616 respondents were included in the analysis. The weighted sample comprised 51.5% women and 48.5% men, with a mean age of 42 years, ranging from 18 to 89 years. The ethnic composition of the sample was 77.0% Chinese, 12.3% Malay, and 8.3% Indian; 2.4% of respondents belonged to other ethnic groups. A majority of the sample was currently married (62.4%) and employed (71.0%). In terms of religious affiliations, a majority of respondents were Buddhists (38.3%), followed by Christians (19.4%), Muslims (14.7%), Taoists (6.3%), and Hindus (4.7%); 16.1% had no religious affiliation or declared themselves "free thinkers." A further .5% belonged to other religions such as Judaism, Zoroastrian, Baha'i, and Sikhism.

Consultation with religious and spiritual advisors

The weighted lifetime prevalence of seeking the help of a religious or spiritual advisor in the overall sample and among those with at least one mental illness was 1.5% and 6.6%, respectively. The prevalence was higher among those with lifetime dysthymia, generalized anxiety disorder, and bipolar disorder (Table 1). The weighted prevalence of 12-month use of religious or spiritual advisors was .3% within the overall sample and 2.0% among those with at least one mental disorder (Table 1).

Correlates of consulting religious and spiritual advisors

Using multiple logistic regression models, we examined the sociodemographic correlates of ever consulting religious or spiritual advisors in our overall sample as well as among persons with at least one mental disorder (Table 2). In the overall sample, we found that compared with Chinese respondents, those from other ethnic groups were less likely to seek help from religious or spiritual advisors. Similarly, compared with Christians, those with affiliations to other religions, including Buddhism, Hinduism, and Islam, were less likely to seek help from religious or spiritual advisors. Respondents with at least one mental disorder were more likely to seek help from religious or spiritual advisors than those without mental disorders. When we further analyzed the sample to include only those with at least one mental disorder, we found that Indians (compared with Chinese) and Buddhists and Hindus (compared with Christians) were less likely to seek help from religious or spiritual advisors. Of those who sought help from a religious or spiritual advisor (N=82), the mean age at time of first contact with these advisors was 30.5 years. A majority (84.6%) of those who sought help in the past 12 months were satisfied with the help received, and more than half (63.9%) of the respondents reported that it helped them "a lot."

Discussion

For individuals with at least one mental illness, the prevalence of lifetime and 12-month use of religious or spiritual advisors, including ministers, priests, monks, or imams, was 6.6% and 2.0%, respectively. Both of these rates are higher than the rate observed for the overall study sample. Our finding that only 6.6% of those with a mental illness consulted religious or spiritual advisors highlights that although religious and spiritual advisors are not the most common source of help for people with mental illnesses, they still play a significant supportive role.

In many cultures, mental disorders continue to be viewed as "nonmedical" illnesses that are caused by abstract elements (26) whereby beliefs and perspectives of illness held by patients, their families, and the local culture all contribute to the explanatory model of the illness. Cultural beliefs and practices affect diagnoses, illness behavior, and the patient's perceived quality of care (27), and as a result, a significant proportion of the population consults religious and spiritual advisors. Furthermore, for some individuals, when a mental or emotional problem arises, they interpret these problems as spiritual and turn to alternative forms of coping instead of formal mental health treatment (28), and religious participation may be substituted for traditional mental health care and reduce or replace the use of such services. Other studies have explored the role of traditional and alternative healers among people with mental illnesses in Singapore (29,30); however, to the best of our knowledge, these have neither included nor focused on religious and spiritual advisors.

Table 2

Sociodemographic correlates of lifetime consultation solely of religious and spiritual advisors in overall sample and in sample with a mental disorder

	Overall sample (N=6,616)					Sample with any mental disorder (N=874)				
	Religious or spiritual advisor only (N=84)		Multiple logistic regression			Religious or spiritual advisor only (N=50)		Multiple logistic regression		
Characteristic	N	Weighted %	OR	95% CI	p	N	Weighted %	OR	95% CI	p
Sex										
Male[a]	38	1.2				23	5.2			
Female	46	1.8	1.05	.63–1.76	.859	27	8.1	1.07	.53–2.16	.845
Age group										
18–34[a]	31	1.2				19	3.4			
35–49	37	2.4	1.22	.63–2.38	.558	21	9.5	1.52	.62–3.71	.357
≥50	16	1.7	.59	.23–1.52	.273	10	7.6	1.21	.37–3.94	.754
Ethnicity										
Chinese[a]	33	1.6				16	7.2			
Malaysian	19	.8	.48	.21–1.05	.067	11	4.2	.43	.15–1.27	.128
Indian	26	1.3	.42	.10–1.83	.249	19	6.2	.19	.04–.86	.032
Other	6	2.3	.32	.11–.97	.044	4	4.8	.26	.06–1.17	.079
Marital status										
Single[a]	23	1.4				16	5.9			
Married	52	1.5	1.34	.66–2.72	.417	27	6.2	.95	.39–2.31	.914
Divorced, separated, or widowed	9	3.7	2.15	.78–5.96	.139	7	27.4	1.55	.47–5.12	.473
Education										
Primary and below[a]	9	.5				7	4.8			
Secondary	16	1.3	.69	.25–1.90	.475	9	5.2	.40	.12–1.37	.145
Tertiary	59	2.0	1.52	.53–4.32	.435	34	7.6	.95	.28–3.21	.929
Employment status										
Employed[a]	56	1.5				35	6.2			
Economically inactive	15	1.7	1.26	.62–2.56	.527	5	8.0	.61	.19–1.97	.411
Unemployed	5	1.4	1.32	.44–3.96	.618	4	6.5	1.50	.41–5.43	.541
Income										
Low <SG$20,000[a]	38	1.3				23	6.3			
Middle SG$20,000 to SG$49,999	27	1.9	1.03	.54–1.99	.927	17	7.9	1.07	.45–2.54	.871
High ≥SG$50,000	15	1.4	.77	.33–1.81	.546	8	4.5	.89	.27–2.99	.853
Religion[b]										
Christianity[a]	44	6.0				23	22.6			
Buddhism	4	.4	.06	.02–.18	<.001	2	1.8	.06	.01–.29	.001
Hinduism	8	.7	.16	.06–.43	<.001	6	3.3	.28	.08–.97	.045
Islam	26	.9	.25	.07–.90	.033	18	5.4	.69	.20–2.36	.558
Any mental disorder[c]										
No[a]	34	.8								
Yes	50	6.6	10.10	6.07–16.80	<.001					

[a] Reference group for multiple logistic regressions

[b] Due to small number of cells and poor model fit, data were removed for free thinkers, Taoism, and other religions in multiple logistic regression models.

[c] Composite International Diagnostic Interview 3.0 data

A number of studies conducted in the United States (31,32) and Europe (7,33) have examined consultation of religious and spiritual advisors for mental health problems. The WHO World Mental Health Surveys found that worldwide the United States had one of the highest rates (18.8%) of help seeking from non–health care professionals, including religious and spiritual advisors, among respondents who reported receiving services in the past 12 months for problems with emotions, nerves, mental health, or use of alcohol or drugs (34). In another study, Wang and colleagues (32) sought to determine the role of clergy in providing support to people with mental disorders and found that 25% of those who ever sought help for mental disorders did so through a member of the clergy. Kovess-Masfety and colleagues (7) studied the role of religious and spiritual advisors in mental health care in six European countries and found that only .6% of their total sample had sought help from religious and spiritual advisors for mental health problems in the previous 12 months. Engaging religious and spiritual advisors for help with mental disorders is more common in the United States than in Singapore, which may be due to relative availability of these services, differing attitudes toward

religion (33), or cultural and ethnic differences and beliefs.

Results from our study showed that the prevalence of consulting religious and spiritual advisors was highest among persons with lifetime dysthymia, bipolar disorder, or generalized anxiety disorder. Findings from Wang and colleagues (31) indicated that the use of "non–health care human services," including religious and spiritual advisors, varied according to mental illness, where a higher prevalence was observed among those with mood disorders. A recent qualitative study by Buus and colleagues (35) concerning people with depressive disorders found that a majority believed that the etiology of their depression was psychosocial and did not draw on specific biological explanations. Similarly, Dejman and colleagues (36) found that coping mechanisms of persons with a depressive disorder involved seeking social support from family and neighbors, religious practice, engaging in pleasurable activities, and seeking medical support from psychologists and family counselors. Thus religious practice and seeking help from religious or spiritual advisors would match the explanatory model of illness and partly account for our findings.

The significant distress associated with anxiety can lead persons to turn to religion as a coping mechanism. Studies have shown that religion helps patients with an anxiety disorder to deal with their symptoms, and religious interventions appear to be effective in the management of the disorder (37,38).

In our study, among persons with at least one mental illness, Christians were more likely than Buddhists and Hindus to seek help from religious and spiritual advisors for mental health problems. Previous research has shown that clergy of various Christian denominations reported spending between 10% and 20% of their time on counseling activities; they have a significant role in helping persons with mental illness and are often described as "front-line mental health workers" (39). On the other hand, a study conducted in central India (40) found that most people with mental illness first sought treatment from faith healers (people who practiced witchcraft), who applied magico-religious practices. A study by Swami and colleagues (41) conducted in Malaysia found that on examining the differences between religious groups in responses to the statement, "When I'm ill, how quickly and effectively I recover is due to…," Buddhists scored the lowest on the choices of religious and supernatural factors. This finding may partly explain why help seeking from religious and spiritual advisors in our study was lower in this group.

How a person perceives mental illness is one of the key influences relating to help-seeking behavior (42,43), and service users' perceptions of mental illness are both personally constructed and culturally shaped (44). Ethnic groups within a country also have been found to have varying perceptions of mental illness (45,46), and sociodemographic factors, such as age, gender, and education, may also influence mental illness perceptions (47). In our study, however, sociodemographic correlates for gender, ethnicity, and education levels were not associated with help seeking from religious and spiritual advisors.

Although only 6.6% of respondents with at least one mental illness sought help via a religious or spiritual advisor, most respondents were satisfied with the support they received, and over half reported it to be very useful. Several studies have shown that contact with religious and spiritual advisors represents a key entry point into the mental health care system (48–50). Although religion and spirituality have been accepted as important contributors to mental health care, there is a need for further research to establish their acceptability (and efficacy in treating mental disorders) within the wider mental health community and general public (10). Furthermore, mental health professionals need to better understand the spiritual values of their patients and incorporate these into assessment and treatment. In the provision of care for mental health problems, it is important that service providers from different settings work together to provide and promote holistic treatment.

One challenge that providers of conventional services face is determining why a considerable proportion of patients seek help from alternative providers and whether the appealing aspects of alternative care can be adopted by conventional providers in order to increase the attractiveness of evidence-based treatments (31). However, the design of our study did not permit us to determine why people sought help from various types of providers.

Other limitations should be considered within the context of our study. Because we sampled households, the survey excluded individuals who were institutionalized at the time of the survey. The SMHS also used a modified version of the CIDI 3.0, which examined only certain mental illnesses; also, we excluded other mental disorders, such as schizophrenia. This study relied on self-reported responses, which may be subject to recall bias, and we were unable to ascertain sequential steps in the pathways to treatment for people with mental illnesses. Finally, because of the structure of the CIDI 3.0, which measures the use of services for mental health problems with a single question and does not describe various mental disorders and their symptoms to respondents, contact with professionals and services might be underestimated (51).

Conclusions

Despite these limitations, the SMHS is the first nationally representative population study in Singapore to capture and describe residents' help seeking from religious or spiritual advisors for mental illnesses. Although use of religious and spiritual advisors was not particularly common in the overall sample, it was more common among persons with mental illness. Furthermore, a majority of persons who sought help from these service providers were satisfied and found their services useful. These findings emphasize the need to promote and encourage increased collaboration between service provider types, including those from traditional health care settings and from more alternative sources, such as religious

and spiritual advisors, to best meet the needs of people with a mental illness.

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