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Recognizing spirituality in the assessment and prevention of suicidal behaviour

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Abstract *Parallel to the growing interest in spiritual life in mainstream culture, in Western culture there has been an increasing distinction between religion and spirituality. This article defines the concept of spirituality and its constitutive elements and presents evidence from the literature to show that, in spite of its importance for mental health patients and suicidal people, it is still an overlooked area in Suicidology. Not only are there relatively few studies addressing this topic, but 'religion/spirituality' is usually just one of a series of variables, generally measured with a single question (mainly inquiring about church attendance/affiliation). Furthermore, studies on non-religious forms of spirituality are rare. Attention is also given to meaning and purpose in life, a central aspect of spirituality that has been generally neglected in suicide research. Some examples of instrument to measure spiritual constructs are provided, with a particular focus on meaning/purpose in life. The paper concludes with suggestions for future research and stressing the importance of considering spirituality in the clinical assessment and treatment of suicidal behaviour.*

Key words: Spirituality, spiritual, religion, religiousness, culture, cross-cultural, meaning and purpose in life, suicide, self-harm, mental health, well-being

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"As you ought not to attempt to cure the eyes without the head,
or the head without the body,
so neither ought you to attempt to cure the body without the soul…
for the part can never be well unless the whole is well…
And therefore, if the head and body are to be well,
you must begin by curing the soul; that is the first thing."
(Plato, 380 B.C.)

Introduction In pre-modern times, concerns related to illness and healing were often encompassed within the wider domain of a religious worldview and, in many cultures, healing was a sacred art (Bathgate, 2003). Today, (Western) Medicine, including Psychiatry, and in general Psychology, are secular disciplines. But, as observed by D'Souza (2002), in many parts of the world a holistic view of human being has survived. This is seen, for instance, in Chinese and Indian Medicine, in the healing arts of American Indians and among Indigenous Australian peoples. However, as Swinton (2001) points out in his *Spirituality and mental health care. Rediscovering a 'forgotten' dimension*, albeit the idea of spirituality appears to belong to a surpassed era, in fact, the latter part of the twentieth century has seen a noticeable rise in interest in spirituality within the Western world[1]. But, as Swinton (2001) clarifies later, this does not refer to institutionalized religions, which are becoming less popular: "whilst people may be becoming less *religious* (Italic in

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the original), it would be a mistake to assume from that that they are necessarily becoming less *spiritual* (Italic in the original)", (p. 11).

The growing positive connotation of spirituality, which contrasts the negative connotation of religiousness, has been pointed out also by Turner, Lukoff, Barnhouse and Lu (1995, cited in Dein, 2005)[2]. The distinction between religion and spirituality has gained greater prominence since the 1960s (Dein, 2005) and, nowadays, there seems to be general agreement (e.g. Birnbaum & Birnbaum, 2004; Burkhardt,1989; Doka & Morgan, 1993; Doyle, 1992 cited in Aldridge, 2000; Fetzer Institute, 1999; Hay, 1989; Oldnall,1996; Sullivan, 1993) about the necessity to differentiate between these two concepts. Despite Ramsey and Blieszner's (2000) radical opinion that we should substitute the word "religion" with the word "spirituality", it is necessary to maintain both words, keeping in mind that religion and spirituality do not necessarily overlap for everyone and individuals may be spiritual without being religious (unreligious spirituality) and religious without being spiritual (unspiritual religiosity). In fact, Oldnall (1996) affirms that the concept of spirituality may exist in every human being, but may consist of either a religious (for example, Judeo-Christianity) or a secular dimension (atheism or humanistic views) or a combination of the two (agnosticism). Burkhardt (1989), as well, distinguishes between the two concepts, stating that spirituality is the essence of one's human nature, whether or not it is expressed through religious beliefs or practices. Zinnbauer, Pargament, Cole, Rye and Butter (1997, cited in Dein, 2005) suggest that religiousness has increasingly become described as "narrow and institutional", whereas spirituality has increasingly been specified as "personal and subjective". Lerner (1994, cited in Aldridge, 2000) states that spirituality is the source dimension behind every religion and should be considered closer to the source dimension than religion that, in his opinion, has moved far from the experience of the spirit and primarily serves moral and social purposes. Consequently, religion -defined more narrowly as a formal, ritualized and institutionalized system of beliefs- should not be treated as synonymous of spirituality but, eventually, as one form of spirituality (or the most common cultural representation of spirituality, in Eckersley's -2007- words).

After a brief discussion on the definition of spirituality, this paper will present evidence from the literature that, in spite of the importance spirituality might have for mental health patients and suicidal people, it is still an overlooked area in Suicidology. Attention will also be given to a central aspect of spirituality that has, with few exceptions, been neglected in suicide research, i.e. meaning and purpose in life. Suggestions for future research are offered in the closing section.

Definition of Spirituality Although generally speaking spirituality is meant as a broad and inclusive term that refers to the non-material aspects of human being, Burkhardt's review (1989) reveals that the concept of spirituality is used in different ways by different authors. Dein (2005) agrees that there is little consensus about what the word means. Aldridge (2000) lists 24 definitions that have been proposed for spirituality, organizing them in four tables. For example, he cites Muldoon and King's (1995) description of spirituality as "the experiential integration of one's life in term of one's ultimate values and meanings" (p. 27) and Reed's (1987) definition as "personal views and behaviors that express a sense of relatedness to a transcendent dimension or to something greater than the self" (p. 28). The Oxford English Dictionary (cited in Miller & Thorsen, 2003) offers 10 pages of reference material on the concept of spirituality! The Mental Health Foundation report (2006) observes how "spirituality is a word used in an abundance of contexts that means different things for different people at different times in different cultures" (p. 6). Miller and Thorsen (2003) note that spirituality as a term tends to elude tight operational definition and argue that "it often seems easier to point to what spirituality is not (i.e. something material) than to what it is" (p. 27).

Albeit there is not a common and shared definition that can completely encapsulate what is meant by spirituality (or "soul[3]"), some elements are shared among different definitions, seeming to denote central components: faith/beliefs, values, sense of meaning and purpose in life, transcendence beyond the present context of reality or to something greater than the self, and sense of connectedness (with the Universe, Higher power, deity, community and/or nature).
As observed by Dein (2005), there are several ways to attain a spiritual experience. These are highly culturally variable, ranging from meditation, prayer and the use of mantra, to art[4], literature and poetry. The author also lists enjoyment of nature, being valued and opportunities to derive meaning from experiences as activities facilitating spiritual growth. Some of these individual and collective techniques are presented in Bartocci (2004). Before going to discuss the neglect and, at the opposite, the importance of spirituality in mental health and Suicidology, it is worth to note that culture does not only influence the forms of spirituality but that the degree of distinction between spirituality and religion, as observed by Miller and Thorsen (2003), also varies across cultures[5].

Neglect of Spirituality in Mental Health and Suicidology "To date Psychiatry has excluded spirituality apart from seeing it as a form of pathology or pathological response" (Dein, 2005, p. 538). Confirming this impression, in a review of research on religion in four major psychiatric journals from 1991 to 1995, Weaver and collaborators (1998, cited in Swinton, 2001) noted that only 1.2% of the 2766 quantitative research articles reviewed contained a religious/spiritual variable. A slightly better result was found in a review of quantitative research studies published between 1992 and 1996 in five adolescent journals (Weaver et al., 2000), 11.8% of which reported a measure of religion. This result was interpreted by the authors as showing more sensitivity to religious factors in adolescence-related journals compared to psychological and psychiatric journals. The scarce importance given to spirituality/religion in research is reflected in clinical practice. Conway (1989, cited in Sullivan, 1993) criticizes the ignoring of patients' spiritual concerns: "if we are to truly understand, study, and help people change, we must address issues that influence people's lives" (p. 132). Swinton's (2001) observes that while some psychiatrists take issues of spirituality seriously, on the whole they have tended not to acknowledge that spirituality (and, in this case, with the term spirituality I mean a non-theological cultural factor and/or a extramundane psychological dynamic) may have a contribution to make to the process of mental health care. This, in my view, includes also the possibility that, in fact, spiritual/religious concerns or beliefs might play a negative role in the healing process .
The lack of consideration of religion and spirituality is particularly pronounced in Suicidology. In Kehoe and Gutheil's evaluation of suicide assessment instruments (1994), the authors note that, although the psychiatric literature suggests that religion and spirituality are significant and meaningful forces in suicidal patients, the number of religious items included on assessment scales approaches zero. The authors criticize designers of suicide scales, which appear to seek factors that may help to identify people at risk of suicide but ignore the possible impact of what "a person, on the brink of life itself, believes about life and about life after death" (p. 368). In this regard, relevant is the contribution of Webb, who reports (2005) that, during his own struggle with persistent suicidality, he found few health workers with whom he could discuss spiritual matters. He criticizes that: "spirituality, which was so central in my own recovery, was not only absent but was deliberately denied and excluded by Suicidology" (p. 2). To prove the exclusion of this spirituality from Suicidology (or "flatland Suicidology" as he refers to it), Webb observes the lack of references to this topic (a part from the preface) in one of the major textbooks of the discipline[6]. So…why something that seems so central in many people's lives and their recovery from difficult times cannot penetrate inside Suicidology and, more in general, is overlooked by mental health sciences?

Among possible reasons for the neglect of the study of spirituality, there is the difficulty of researching a somewhat vague and abstract concept. Ellison (1983) indicates that terms such as 'spirituality' and 'well-being' have subjective meanings which are impossible to operationalize, and it is for this reason that psychologists –in contrast to sociologists- have ignored the spiritual dimension of human welfare. That spirituality does not lend itself to measurement in a natural science sense, has been postulated by Oldnall (1996) as a reason for the omission of spiritual needs in nursing practice and by Burkhardt (1989) as a reason for the limited research in the same area. In a similar way, Bhugra and Osbourne (2004) believe that seeing religion as primitive, untestable, unverifiable and unscientific is a key factor in why psychiatrists ignore it. Hill and Pargament (2003) also attribute part of the reason for the religion/spirituality gap in health research to the wrong assumption that these issues fall outside the scope of scientific study.

Swinton (2001), at the opposite, argues that spirituality can be studied in a scientific way, although our understandings of science may have to alter to accommodate for the new perspectives that spirituality brings to it. He criticizes the reductionistic traditional scientific attempt to quantify spirituality, stating:

> "Spirituality relates to such things as love, hope, meaning, purpose- things which cannot be fully captured by the traditional methodologies of science. Thus (...) there is a need to develop complementary methodologies and ways of exploring the spiritual dimension that can dig into the hidden depths of human emotion and experience and reveal aspects and perspectives that are unavailable to other ways of doing research"[7] (p. 93).

The author lists other reasons why mental health professionals are wary and skeptical about spirituality:

- the impact of Psychoanalysis and other therapeutic theories negative view of religion;
- lack of personal interest in spirituality/religion;
- professional pride and research credibility;
- fear of incompetence;
- lack of time;
- fear of imposing personal beliefs on the client;
- and fear of intruding on a patient's privacy.

It is also possible that psychologists and psychiatrists are less likely to have religious involvement or clinical training in religious issues than other mental health specialists (Sansone et al., 1990, cited in Weaver et al., 2000; Shafranske & Malony, 1990). The lack of personal interest in spirituality and religion as linked to their neglect is supported by Baetz, Larson, Marcoux, Jokic and Bowen (2002) who showed that, if the carer has personal interest in religion, they will more likely consider this construct during the therapy. The psychiatrists interviewed were all members of the Christian Medical and Dental Society (CMDS) and 80% of them declared that they often or always inquired about their patient's religious beliefs. Two thirds of them felt they were satisfactorily able to integrate spiritual issues into their practice if they chose to do so. In another study (King, Sobal, Haggerty, Dent & Patton, 1992), physicians who had strong religious beliefs (and those who were Protestants) were more likely to discuss religious beliefs with patients. However, it must be noted that although most physicians had strong religious beliefs, only one third felt that they should ask their patients about faith-healing experiences. Moreover, Koenig and collaborators' finding (1991, cited in Hill & Pargament, 2003) that mental health professionals seek out referrals from religious groups, but rarely make referrals to clergy or other religious leaders is of dubious interpretation. Is it for the professional pride mentioned above by Swinton or rather for a sense of self-sufficiency or both?

Basically, a definitive answer awaits further research that addresses the question <<why patients' religious and spiritual dimensions are neglected by psychiatrists?>> (Kehoe & Gutheil, 1994).

Colucci and Martin (in press) have reviewed studies which have examined the variables of religion and spirituality in the context of suicidal behaviour. As the authors point out, not only has spirituality been overlooked by suicidologists, but the studies have typically been restricted to the analysis of the relationship between religiosity (often operationalized as church affiliation or attendance) and suicidal ideation/attitude or suicide mortality statistics. Very rarely have researchers addressed non-religious form of spirituality or used a qualitative methodology. If the picture emerging from this summary is unsatisfactory, it becomes even more disappointing when we note that the findings about the influence of religion on suicide are inconsistent and ambiguous. The authors recommend methods for future research to enhance the quality and utility of studies in this area, and to shed light on spirituality, the importance of which is discussed in the following paragraph.

There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy
(Shakespeare, From Hamlet, Prince of Denmark, 1601, Act I: Scene 5)

Importance of Spirituality for Mental Health and Suicide Prevention The impact of Eastern spiritual thought, the emergence of New Age philosophies and the popularity of alternative health practices have all called for a more holistic understanding of health related issues (D'Souza, 2002). Over recent decades, professionals in several sectors of health have suggested to give more importance to spirituality in the healing process and health models (e.g., D'Souza, 2002; Koenig, 2000; Marsella, 1999; Oldnall, 1995; Ramsey & Blieszner, 2000; Underwood & Teresi, 2002) and mainstream medical journals have acknowledged the area of spirituality (Dein, 2005). The change, however, seems to be more rhetoric than the reality of practice. For instance, in the area of general health, although physicians seldom question patients about their religious beliefs, patients express a desire for physicians to consider their spiritual needs (King & Bushwick, 1994). The Mental Health Foundation report (2006) underlines that some find that their religious/spiritual beliefs are not understood or explored within mental health services: "For many, clinicians either ignore an individual's spiritual life completely or treat their spiritual experience as nothing more than manifestations of psychopathology"[8] (p. 3). To this I add that another risk is that even clinicians who do not neglect their patients' spiritual needs might have a limited perspective on this matter and identify spirituality with religion. Thus, people whose spirituality has a non-religious expression might be offered even less opportunities of sharing their spiritual beliefs and/or concerns.

In the Fetzer Institute report (1999) are listed various ways in which religiousness and spirituality may be connected to health outcomes:

- religiousness/spirituality provides supportive, integrative communities for their members;
- offers members a complex set of beliefs about God, ethics, human relationships, life and death, which are beneficial to health;
- may protect against disease, indirectly promoting healthy lifestyles (e.g. healthy diets or prohibition to smoke and use drugs) and
- certain religious/spiritual practices affect physiological mechanisms and elicit relaxation responses.

Religion also helps patients to cope better with their illness: the majority of 850 studies on religion and mental health reviewed by Koenig (2000) reported that religious people experience better mental health and adapt more successfully to stress.

In Sullivan's study (1993) half of the mental health services consumers indicated spiritual beliefs and practices as central to their successful struggle with severe mental illness. The author then speculates that the results can reflect the role of spirituality as a coping strategy, a source of social support and a system of meanings. Coping styles was one of the mechanisms though which

potential benefits of spirituality on mental health may occur listed in the Mental Health Foundation report (2006). The others are: locus of control, social support and social networks, physiological mechanisms, and architecture and the built environment (including nature, art and music).

However, it must be considered that an interest in religious issues may be not shared by every patient and it is likely to be higher in more religious patients. In fact, in Exline, Yali and Sanderson's (2000) investigation of the role of religious strain in depression and suicidality, the authors found that religiosity was positively associated with interest in addressing religious issues during treatment with a clinical sample of persons seeking psychotherapy. On the other hand, religion can be of such importance that some persons with mental heath disorders frequently, and sometimes only, seek help from the clergy (Larson et al., 1988, cited in Baetz et al., 2002). The authors speculate that one of the possible reasons is people's fear of having their own spiritual needs and their faith overlooked or misinterpreted. This fear precludes those people from getting medical or psychological help, and the only way to improve access would be a change in the neglect and skepticism towards spiritual issues by mental health professionals. In particular, there is the risk that "non-religiously spiritual" people are left unable to find an outlet to express any kind of extramundane beliefs and concerns (i.e., mental health professional are not interest in the topic and priests might try to indoctrinate them). As Koenig (2000) notes in discussing the danger of not considering one of the three dimensions of the person (physical, emotional and spiritual): "for many patients, spirituality is an important part of the wholeness, and when addressing psychosocial aspects in medicine, that part of their personhood cannot be ignored" (p. 1708). This may be more important for psychiatric patients, as evidenced by Swinton (2001): "While spirituality remains a peripheral issue for many mental health professionals, it is in fact of central importance to many people who are struggling with the pain and confusion of mental health problem" (p. 7).

Religion and spirituality not only influence mental health and beliefs about mental illness but treatment can be affected as well (Bhugra & Osbourne, 2004; Chiu, Ganesan, Clark & Morrow, 2005). For instance, some religious groups will refuse to take capsules made from gelatine. Bhugra and Osbourne(2004) recommend that the role of religion/spirituality "in individual's cultural identity must be taken into account when ascertaining mental state and formulating management strategies" (p. 6)". Shafranske and Malony (1996, cited in Johnson & Hayes, 2003) suggest that religion/spirituality needs to be considered like any other client cultural characteristic and mental health professionals have an ethical obligation to consider spirituality a part of a standard assessment.

In spite of the awareness of the role of the spiritual dimension in mental health and illness, only relatively few studies have investigated the role of spirituality in psychiatric patients. These studies reveal that religion/spirituality is important in dealing with mental illness (e.g., D'Souza, 2002; Larson & Larson, 2003; Sullivan, 1993 cited in Swinton, 2001) and, in patients' opinions, should be taken in account by a therapist. In D'Souza's study (2002), for example, 79% of psychiatric patients rated spirituality as very important and 82% thought their therapists should be aware of their spiritual beliefs and needs, whereas 69% of them reported that those spiritual needs should be considered by the therapist in treating their psychological illness. Two-third of patients also believed that spirituality helped them to cope with psychological pain.

On the other side, 16% of studies reviewed by Larson and colleagues (1992) evidenced some negative associations between mental health and religion. A review by Gartner, Larson and Allen (1991) suggests that both low and high levels of religiosity can be associated with psychopathology. More specifically, low levels of religiosity are associated with disorders related to undercontrol of impulses, whereas high levels are more often related to disorders of overcontrol. The role of concerns about religion/spirituality as a possible font of distress and focal point for personal strain and conflict has been underlined also by Exline, Yali and Sanderson,(2000) and

Johnson and Hyves (2003). Payne, Bergin, Bielema and Jenkins (1991), in their review on religion and mental health, conclude that "religion as prevention" is a concept based on an illusion that one religion is as good as another, whereas some ways of being religious (e.g. intrinsically instead of extrinsically) are healthier than other ways. In particular, spiritual beliefs which involve oppressive images of God, or which engender inappropriate guilt and increase anxiety, may be detrimental to mental health (Swinton, 2001) and may put the person at risk of suicide. A similar case is made in the Mental Health Foundation report (2006) when the author states that some expression of spirituality are more effective than others in promoting mental health and enabling people to cope when their mental health deteriorates. The argument about a negative impact of religion on mental health needs further investigation, looking both at those religions that, throughout history, have not only sanctioned, but institutionalized suicide, such as Brahmanism, Buddhism and the state religion of Japan (Whalley, 1964) and, on the other hand, religions that traditionally have forbidden suicide, like Catholicism, Judaism and Islam (see Colucci & Martin, in press).

Thakker, Durrant, Schumaker, Nathawat and Palsane (1999) found no meaningful relationship between religiosity and psychological well-being in a sample of university students from India. However, the authors attribute this finding to the pervasiveness of religious beliefs in India, with positive effects that permeate the culture as a whole. The same point is discussed in Dein's cultural analysis of spirituality (2005), where he supports the idea that it may be senseless to distinguish between culture and religion in many parts of the world. Senseless or not, it is certain that religion, as the title of the paper by Tarakeshwar, Stanton and Pargament (2003) says, is an overlooked dimension in Cross-Cultural Psychology as well as Trans/Cross- Cultural Psychiatry. Their article opens: "Religion is inextricably woven into the cloth of cultural life" (p. 377). From this starting point the authors pass through the criticism of the existing cross-cultural research for the limited attention paid to religion and spirituality, list four reasons why religion (and, I add, spirituality) should be fully integrated into cross-cultural research and highlight how religion exercises its own impact on the beliefs and practices of cultures and how, in turn, cultural norms, behaviours and changes shape the manifestation of religion in different countries. Also Thakker and colleagues (1999) are critical of the literature for the absence of cross-cultural investigations of the relationship between religion and mental health and the fact that the few studies done have been mainly conducted on western populations.

People's choice to live or to die is highly related to aspects of their spiritual life (Birnbaum & Birnbaum, 2004). Religion and spirituality may influence the attitudes and beliefs people have toward experience of distress and illness, may be a means for coping with mental health problems, may enhance psychiatric patients sense of social belonging and integration, may be part of people's explanatory model of their life's experiences, may ameliorate the relationship with mental health professionals and enhance the trust and access to mental health services. Furthermore, spiritual beliefs and values are part of the patient's cultural background and their consideration in mental health may help to pursue the important aim of offering culturally-sensitive prevention/intervention strategies. For all these reasons, it is expected (and hoped) that more professionals in general health and in mental health will be able to make an in-depth diagnostic assessment of what kind of spirituality the patient is "imbued with" so to address this aspect when treating their patients. This hope is based on the observation that, even though religious/spiritual issues (as recognized by scholars such as, to cite a few, Birnbaum & Birnbaum, 2004; Greening & Stoppelbein, 2002; Kehoe & Gutheil, 1994) have been generally overlooked in Suicidology, in recent years there has been a growing interest in the role religion and spirituality may play in reducing self-harm and suicidal behaviour[9] (Resnick et al., 1997 cited in Nonnemaker, McNeely & Blum, 2003). The review by Colucci and Martin (in press) analyses the role that religion and spirituality may play at each step along the suicidal path, reporting on research that has considered the relationship between spirituality/religion and suicidal ideation, suicidal attempt

and death by suicide. However, the research has generally focused on religion. Important spiritual elements (e.g. meaning and purpose) have been extensively and unreasonably neglected.

He who has a why to live for can bear almost anything
(Nietszche)

Meaning in Life A particular aspect of spirituality that has not received yet the attention that -in my opinion- deserves is that of the search for "meaning in life". Meaning or a sense of life's purpose has been proposed as a primary component of a definition of spirituality by several authors (e.g., Bhugra & Osbourne, 2004; Daaleman, Cobb & Frey, 2001; Dyson et al., 1997; Garroutte, Goldberg, Beals, Herrell & Manson, 2003; Mental Health Foundation, 2006; Plouffe, 1992 cited in Wong, 1998a). Doyle (1992, cited in Aldridge, 2000) states that spirituality, in essence, means "searching for existential meaning". Tacey (2005) emphasizes that the soul is not nourished by social status or financial success, but only by meaning, value and purpose and that the soul requires meaning that comes from connection to transcendent values. Swinton (2001) affirms that "It is the meaning and purpose that a person has discovered within their life which gives them the strength to find meaning and purpose within their suffering" (p. 58). In fact, individuals who experience a deeper and broader sense of meaning and purpose enjoy greater life satisfaction, higher levels of psychological and physical well-being, and positive mental health (Reker, 1994) whereas, in Petersen and Roy's opinion (1985), people whose lives lack meaning and purpose, experience feeling of emptiness or a lack of direction, have difficulty making sense out of their existence and question the significance of being who or what they are. Antonovsky recognizes meaningfulness as the most important component of the Sense of Coherence (SOC) and concludes that high level of meaningfulness motivates individuals to search for order and to make sense of their environment, as well as kinaesthetically transform their coping resources (1990, cited in Korotkov, 1998). Personal meaning has three components: cognitive, affective, and motivational (Wong, 1998b). The cognitive system consists of beliefs, expectations and schemas, individually constructed and culturally based, whereas the affective component is defined as feelings of satisfaction and fulfillment. In terms of the motivational component, personal meaning is the pursuit of activities and life goals considered by the individual to be valuable and worthwhile. Different authors have underlined different aspects of this construct. For example, Thompson and Janigian (1988) identify purpose and order as the two components of the "search for meaning". In their own words: "An event is meaningful when we understand how it follows in an orderly fashion from our views and beliefs and when it has a purpose whose value we recognize" (p. 263). The sense of commitment is a central part of meaning-making as well, as showed by Kosaba and colleagues (1979, 1982 cited in Thompson & Janigian, 1988) who found that stress resistant people are distinguished by the sense of commitment in their lives. "Hardy" people tend to have a strong sense of purpose: not only they have goals in their lives but a strong sense that those goals are important, of value, and they are actively involved in attaining them. Depression, in this view, results from the perception that important goals no longer appear to be achievable (Thompson & Janigian, 1988) or, in my opinion, that they are no longer important, meaningful. A number of studies have found significant relationships between the sense of meaning in life and indices of health, particularly mental health (Fetzer Institute, 1999). Personal meaning plays both a health-protecting and a health-enhancing role and the mechanism underlying this effect is, in Reker's opinion (1994), through cognitive restructuring or, more explicitly, through restructuring, redefining or re-evaluating stressful situations in order to reduce their negative impact. Some research shows that life meanings may be more influential in psychological well-being than religion per se. For example, Chamberlin and Zika (1992, cited in Thakker et al., 1999) found -in two studies- that, although religiosity and life satisfaction correlated, when life meaning was

factored in, religiosity contributed little to life satisfaction. This result suggests that life meaning may mediate the relationship between religiosity and well-being.

Personal meaning has been a core concept for several phenomenological philosophers and existential scholars[10]. The most notable and influential is Victor Frankl, a psychiatrist survivor of a Nazi concentration camp in Germany. Frankl (1963) suggested that the primary motivating factor of mental health is the human quest for meaning and purpose, which belongs to the *noetic* dimension of human beings. This concept was so important to him that he developed a therapeutic approach - *Logotherapy*- which focuses on meaning in life. Human survival depends on finding and preserving meaning and on filling the "existential vacuum", "a feeling of aimlessness and emptiness" (Frankl, 1966). Man is characterized by his reaching out for meaning and purpose in life. The lack of meaning, in Frankl's view, is experienced by the individual as a sense of complete emptiness, and an absence of purpose for continuing to live. Suicide, then, may seem a viable solution to relieve this distressing state of being (Edwards & Holden, 2001). A similar concept is affirmed by Fitzpatrick (1983, cited in Moore, 1997), Marsella (1999) and Tacey (2005)[11]. The former asserts that those who have no meaning attached to life do not continue to live. Marsella (1999) states the centrality of meaning along life's journey, the absence of which causes despair, alienation and suicide. Marsella declares: "It seems to me that many discomforts, disorders, and diseases of our time are related to an absence of meaning-seeking and meaning-making" (1999, p. 49). Tacey (2005) criticizes our "rational" society for ignoring the soul[12] -"the unattended soul"- and states that this hollowness may express itself as despair, chronic anxiety, deep uncertainty, various kinds of addictions, or suicidal feelings. He states: "Spirit is seen as too abstract for science to be bothered with, and yet this is an illusion: nothing is more concrete than a reality that bestows purpose and value to life" (p. 109). Tacey (2005) also sees the archetypical background of youth's self-mutilations in the initiation rituals: there is a desire to mark the body, to announce that one has been touched by something decisive, to mark their passage from one state to another. Moreover, Webb (2003) -from his "first-hand" experience- argues that hopelessness is the main indicator of suicidality and that hopelessness arises from an absence of meaning or purpose in life. For Frankl (1966) meanings are both relative and subjective: meaning differs from man to man and day by day. Consequently, there is no universal meaning of life although some meanings are shared by human beings throughout society and history (meanings which, in Frankl's theory, are understood as values). Frankl concluded that there are three types of values whereby an individual can discover meaning: creative (based on what the person gives to the world, such as achievements and good deeds), experiential (what the person receives from the world), and attitudinal (realized by adopting the right attitude towards situations). Later research by Reker and Wong (1988, cited in Wong, 1998a) and Ebersole (1998) examined the central source of meanings for people and found as representative sources: leisure activities and hobbies; relationships; personal achievement and growth; religious/spiritual and social/political values and beliefs; social and political activism and service; traditions and culture; creative work; life work; materialistic and basic needs.

Although it appears obvious that at least a number of suicides are an expression of absence of meaning in life or "attempts to escape from an existential vacuum" (Wong, 1998b, p. 413), studies into this aspect are very rare (e.g., I came across only to Edwards & Holden, 2001; Harlow, Newcomb & Bentler, 1986; Lester & Badro, 1992; Moore, 1997; Orbach, Mikulincer, Gilboa-Schechtman & Sirota, 2003). Moore (1997), finding no study in the elderly examining suicide and meaning of life, interviewed elderly psychiatric inpatients with suicidal ideation, who revealed feelings of worthless and absence of connectedness with others. "Emptiness" appeared to make a unique contribution to the differentiation of suicidal and no suicidal groups beyond the contribution of depression, hopelessness and anxiety (Orbach et al., 2003). Harlow and collaborators (1986) tested the theory that lack of purpose in life is an essential mediating factor in

the relationship between depression and suicide ideation, but the theory was confirmed only for young males. In a sample of college students, Lester and Badro (1992) found that while depression scores were significant predictors of only current suicidal preoccupation, Purpose-in-Life scores (as measured by PIL, see later) were significant predictors of current suicide ideation as well as a history of previous ideation and threats. Edwards and Holden (2001) examined the relationship between coping strategies and purpose in life with suicidal manifestations in undergraduate Canadian students. Purpose in life correlated negatively with both suicidal ideation and likelihood of future suicidal behavior. The authors concluded that suicide prediction, prevention and intervention strategies may be enhanced if they address life meaning. Wong (1998b) reported that evidence suggests that promotion of personal meaning may be effective in addressing social problems, such as drug addiction, alcoholism and suicide. Although not focused on meanings, Foster's (2003) examination of suicide notes pointed out the presence in "hopelessness/nothing to live for" amongst the most common themes, especially in suicides with major unipolar depression. Similarly, in Rogers, Bromley, McNally and Lester's (2007) content analysis of suicide notes, spiritual motivation was present in 25% of the notes (particularly in younger writers) and many of these had a more existential component of loss of meaning and purpose in life than a specific reference to more traditional conceptualization of spirituality. Lester (1998) offers a different perspective in regard to the role of meaning in suicidal behaviour stating that, for some suicidal individuals, suicide is a search for spirituality, for God, for the meaning of life and for rebirth, although this has been criticized by Fournier (1999). On the side of survivors, the study of Currier, Holland and Neimeyer (2006) on violent loss (including suicide) found that the failure to find meaning in a loss is a crucial pathway to complicated grief. The authors also suggest that religion and spirituality might influence such sense-making.

Sense of meaningfulness can be increased through therapy. Wong (1998b), for example, proposed a culturally-appropriate meaning-centered counseling, a hybrid between existential-humanistic Psychology and cognitive-behavioral therapy, growth oriented instead of problem focused. D'Souza and Rodrigo (2004) developed the *Spiritually-augmented Cognitive Behaviour therapy* which includes techniques to find meaning and purpose (i.e. meaning of the situation and global meaning). As noted before, Frankl suggested three approaches for increasing meaning: "giving to the world", "taking from the world" and through the attitude toward inevitable suffering. In the Sappington, Bryant and Oden's study (1990) of Frankl's hypothesis, students scoring low on purpose in life were randomly assigned to two treatments: the first aimed to increase meaning through helping others (the "giving to the world" approach) and the second through increasing enjoyment and appreciation (i.e." taking from the world"). Both experimental groups increased their purpose in life significantly more than the control group. Is it then possible to treat suicidal patients to make their lives more meaningful, helping them to find purpose in their lives? This study would suggest so but, incomprehensibly, at the moment there are too few studies to be able to answer this question. The reasons why meaning in life has been neglected in this area of research and -more broadly (as noted by Ryff & Singer, 1998), the connections between goals, purpose and meanings with health and well-being are largely unexplored- are similar to those discussed earlier for, more in general, spirituality: the absence of a shared definition of the construct, the uncertainty about what is meant by 'meaning' and difficulty in operationalizing and quantitatively researching the concept. Wong (1998b) points out that it is a common viewpoint that questions about meaning and purpose are too subjective and philosophical to be answered scientifically. Ebersole (1998) suggests as well that this concept of meaning apparently lacks demonstrated practical value. Despite this, he proposes some applications of meaning and strongly recommends doing more research in the area. In recent years, issues related to meaning and purpose are receiving increasing attention by researchers (Wong, 1998b) but this does not seem to be happening in Suicidology. My hope is that other scholars will share my feeling that

more research in this important direction is needed and the number of publications on this topic will see an increase in the near future. Part of this research should, in my opinion, embrace Antonovsky's (1987, cited in Korotkov, 1998) critique of the "disease model" so prevalent in Psychiatry and Psychology, and should address what keeps people alive, even when life has been particularly difficult for them. In this way, attention might shift from suicide prevention to the more promising sector of life promotion.

Scales Measuring Religiosity and Spirituality As concluded by Kehoe and Gutheil (1994), front-line clinicians do not regularly investigate the religious area of a person's life as a factor in assessing suicidal risk. But, for those mental health professionals sensitive to patients'spiritual needs, scales are available which could potentially become part of the clinical assessment of a suicidal person (as well as anyone else). The *Daily Spiritual Experience Scale* (Underwood & Teresi, 2002) is a scale intended to transcend the boundaries of a particular religion. It measures a person's perception of the transcendent involvement and interaction in daily life. The *Spiritual Well-Being Scale* (Paloutzian & Ellison, 1982 cited in Ellison, 1983) is intended to assess both the vertical and the horizontal components of spiritual well-being, i.e. the religious and existential well-being. A tool for spiritual assessment has been offered by Hay (1989), who has identified four "spiritual diagnosis categories" – spiritual suffering, inner resource deficiency, belief system inquiry and religious need- and for each of them he proposes a specific assessment, goals and interventions. The same author (2001, in Hill & Pargament, 2003) has also designed the *Spiritual History Scale*, which captures the dynamic qualities of religion and spirituality. The Fetzer Institute and the National Institute of Aging (1999) convened a panel of scholars with expertise in religiousness/spirituality and health/well-being to develop items in order to assess health-relevant domains of religiousness and spirituality. The instrument *Multidimensional Measurement of Religiousness/Spirituality* is composed of various scales representing different domains of religiousness and spirituality (e.g. meaning, values, beliefs, private religious practice, religious/spiritual coping). Hill and Pargament (2003) have divided religion and spirituality constructs related to health in four categories –closeness to God, religious orientation and motivation, religious support and religious struggle- providing examples of existing measures for each of them. The *Life Attitude Profile* (Reker & Peacock, 1981; 1992, cited in Fetzer Institute, 1999), the *Purpose-in-Life* test (Crumbaugh & Maholick, 1964 cited in Chang & Dodder, 1983) and the *Seeking of Noetic Goals Test* (Crumbaugh, 1977) were developed to measure Frankl's concept of meaning and purpose in life. While the Purpose-in-Life (PIL) test indicates the degree to which meaning and purpose in life has been found, the Seeking of Noetic Goals test measures the strength of motivation to find meaning in life. Battista and Almond (1973) have emphasized the individual's process of believing rather than the content of their beliefs. Following their relativistic perspective of personal meaning (i.e. there is no an ultimate meaning and coexist divergent ways of reaching a sense of meaningfulness), they designed the *Life Regard Index* (LRI), a 28-item Likert scale consisting of two subscales: a *Framework* scale and a *Fulfillment* Scale. A revised version has been developed by Debats (1998). Ryff's Purpose-in-Life subscale (Ryff & Keyes, 1995) assesses the degree to which a person has goals in life, holds beliefs that give life purpose, and perceives meaning in the present and past. The Sense of Coherence scale (SOC) was developed from Antonovsky's theory cited before.

A slightly different instrument -which could complement the assessment of meaning/purpose in life- is the *Reason for Living Inventory* (RFL) by Linehan, Goodstein, Nielsen and Chiles (1983). This requires a rating of how important each of 48 reasons would be for living if suicide was contemplated. These are just some of the scales that have been developed for the assessment of a person's spiritual/religious beliefs[13]. Of course, spirituality and religiosity may be investigate more in depth using a qualitative approach (see next section) and these scales are a suggestion for

clinicians and researchers who prefer or need to use structured and statistically validated measures. However, whatever method is used (both in research and clinical practice), it is fundamental to use instruments that are not restrained only to religiosity, excluding non-institutionalized forms of spirituality and keep in mind, if religion is the topic under investigation, that the great many of religious measures have been geared to members of Judeo-Christian traditions (Gorsuch, 1988 in Hill & Pargament, 2003). This is important because, as underlined also by Venkatachari (1996, in Tarakeshwar et al., 2003), for some religious groups (e.g. Hindu), some of the items (e.g. frequency of temple attendance) may not be integral to their religious practice and using an inappropriate instrument will provide misleading results.

Future Direction Linked to what just written above, Birnbaum and Birnbaum (2004) speculate that one of the reasons for the dearth of writing on the topic of spirituality and suicide may be related to the view that spirituality is necessarily and directly linked to religion. Miller and Thoresen (2003) observe that, with rare exceptions, the available literature has measured religious rather than spiritual variables. The same criticism was made in the review by Colucci and Martin (in press). Also the Mental Health Foundation report (2006) points out that, whilst there is recognition that there are differences between religion and spirituality, much of the research uses measures of religious practice as a proxy. But, as Swinton (2001) affirms, the significant thing to bear in mind is that spirituality may well be significant to many people with mental health problems, even though they may not express an interest in or adherence to an established religious tradition. For instance, Webb (2003) admits that a faith-based religious spirituality was not going to work for someone with a rationalistic and atheistic upbringing like his but that this form of sacred relationship with a religious God has been the key to the recovery of other suicidal patients. Therefore, research should attempt to discover those aspects of life that give meaning to individuals that are beyond the traditional parameters of religion (Mental Health Foundation, 2006). Consequently, the first suggestion for future direction in research is to focalize on the broader concept of spirituality, on the feeling of transcendence. Research should address the personal and cultural ways of experiencing and expressing spirituality, such as art forms (see note 4), meditation, spiritual rituals (for examples, pragya, of fire ceremony, in India) and mystical experiences. Researches should also address the knowledge of the biopsychocultural roots of that experience generally named religious experience (see Bartocci & Dein, 2005). There is sometimes the feeling that the current "scientific" understanding of suicide lacks highly relevant information on the lives, experiences and beliefs of suicidal individuals and this is, in Birnbaum and Birnbaum (2004) opinion, simply because it is not amenable to traditional, rational quantitative approaches. One of the limits shown by quantitative studies of religion is that usually they are reductionistic, simplistic and treat religion and spirituality as if they are unidimensional constructs, often assuming that these can be adequately measured by a single variable. In fact, one of the most frequent measures of religiosity consists in a question on church attendance which may not be a reliable measure because of the complexity of this kind of constructs (Hunsberger, 1985). In the cross-cultural journals reviewed by Tarakeshwar et al. (2003), the authors criticize that the religious dimension was assessed through a few global indicators (such as church affiliation, church attendance and prayer) which do not reflect the multidimensional nature of religion. One reason for the use of brief (generally single-item) indices is that, as also underlined by Hill & Pargament (2003), religion and spirituality have often been included only as add-on variables in the context of other research agendas. Miller and Thoresen (2003) are critical of operational definitions of spirituality that do not consider that spirituality, first of all, is not dichotomous (i.e. it is not an attribute that is either present or absent in an individual) and cannot be defined as a single linear dimension (e.g., something than one has more or less of). The Mental Health Foundation report (2006) also indicates that one of the key shortcomings in mental health research is that:

> "(…) it relies exclusively on quantitative measures, which may not fully access the meaning spiritual activity has for the individual. Quantitative research tends to try and isolate the impact of one activity (e.g. church attendance) upon another (e.g. level of depression), which may not always capture the rich and complex interactions of other factors on any association found (p. 25)".

Swinton (2001) is also very critical of the use of quantitative methods to study religion and spirituality and similarly points out:

> "While they may be able to measure the frequency of an action or the commonality of proclaimed beliefs, they fail to take cognizance of the *meaning* (Italic in the original) that such thing have for people...To understand the possible benefits or otherwise of religion for a person's mental health, it is necessary to know what their religion means to them as individuals, how this is worked out in their lives and the ways they use it to understand and come to terms with their life experience" (p. 35).

Burkhardt (1989) supports the opinion that spirituality lends itself more to qualitative measures, where subjectivity of response is valued. Qualitative research, I add, is the only way to access the deep and personal meanings (i.e., the "what is it like?", "what is it about spirituality that…?" kind of questions), therefore, it is necessary to increase the use of qualitative methodology in the current research. More specifically, Daaleman, Cobb and Frey (2001) found focus group discussions a well-suited method to investigate patient-reported spirituality. Perhaps, as suggested in the Mental Health Foundation report (2006), to gain a fuller understanding of the link between spirituality and mental health/illness, researchers need to use a combination of methodologies that allow the complexities of the field to be explored. More in general, researchers (in this field as in any other) should ensure that the methodology and the methods employed are the most appropriate to answer the questions being addressed (i.e. the method should reflect the same epistemology and "level of reality" of the research aims). Another limitation of research in this field underlined in the Mental Health Foundation report (2006) is that the literature focuses on the effects of spirituality on mental health problems whereas few studies address the mechanism though which spirituality may promote good mental health and wellbeing in populations without those problems. From what written until now is evident that more and better research is needed in this direction.

A fundamental aspect of spirituality -meaning in life- needs to be addressed in more research on suicidal people (and not only) and more research is required to define which aspects of religiosity and spirituality are protective against suicide, because religious affiliation or simply attending church are not "necessary and sufficient" conditions to prevent suicidal behaviour. In this regard, Whalley (1964) sarcastically notes that "unless the suicides represent an entirely separate subgroup within the population, a great many of the people who killed themselves must have been active church members and most would at least have professed to believe in God" (p. 91). This supposition finds some support in Sorri, Henriksson and Lonnqvist's (1996) study, where overt active religiosity was identified in a fifth of Finnish who killed themselves. Similarly, following Allport's assertion (1950, in Hill & Pargament, 2003), it might be more important to ask "how" a person is religious rather than "whether" a person is religious. It would also be valuable to explore the meanings that people from diverse cultural groups, socio-economic background and life experiences attribute to religiousness and spirituality. There have been plenty of "professional" definitions of religion and spirituality but very little attention has been paid to the ways lay people define and interpret these terms (Dein, 2005). Bearing in mind that differences in religion and spiritual beliefs, practices and affiliations are interwoven into other cultural features, as argued by Hill and Pargament (2003), I strongly believe that it is of paramount importance that measures of religion/spirituality reflect greater sensitivity towards ethnocultural issues. For instance, as suggested by Miller and Thoresen (2003), it must be considered that the magnitude and direction of the effect of spirituality/religiousness on health, may vary widely across ethnic groups that differ with regard to the cultural centrality of religion (and, I add, the spiritual dimension). The need to examine the ways in which culture influences religion's expression of the spiritual has been underlined by Eckersley (2007) as well. Until this does not happen, we risk

asking the wrong questions to our patients and research participants and offering them the wrong solutions/interpretations. Larson and Larson (2003) also recommend more studies addressing religion/spirituality not only to understand better its importance as a coping strategy for mental health patients, but to clarify as well its less frequently found but clinically important harmful use (see Colucci & Martin, in press). I agree that the circumstances where spiritual/religious concerns (or beliefs) have a negative impact on mental health should also be explored.

In my opinion, it is also crucial to introduce spirituality routinely into prevention and intervention plans, given the importance it has for many people with (or without) mental health problems and, as recommended also by Miller and Thoresen (2003), increase research on spiritually/religiously based (prevention/treatment) interventions. As D'Souza (2002) points out:

> "Spiritual issues encompass what is most meaningful and central in human existence. In time of crisis, illness and transition, spiritual issues are likely to come to the fore of human awareness for both patients and professionals. (...) All health care professionals need to include the spiritual dimension in assessment and treatment of patients" (p. 46).

And this may be particularly important in suicidal patients, where topics of meanings and purpose in life, sense of connection and coherence, systems of values and beliefs are all often central issues in their suffering.

Conclusions In the "spirituality revolution" that is taking place during the post-modern era in Western societies -also found in Eastern countries- (Tacey, 2003), any branch dealing with mental health (Suicidology included) is called to recognize people's quest for meaning, that search for the sacred, for something higher; that request to fill that spiritual vacuum left by the "illuministic" and secular society. Spiritual and religious concerns and needs must be examined further and more in depth in suicide research in order to understand their role as protective and/or risk factors for suicidal behaviour, and to exploit the potential of spirituality/religiosity in suicide prevention strategies. Two factors raise my hopes that these aims may be reached in the near future. First of all, Dein (2005) reports an increasing interest in religion among psychiatrists and psychologist (which I expect will soon spread also to non-religious/theological spirituality). Second, the fact that "religious and spiritual problem" has been added as an Axis I category in DSM-IV under "Other conditions that may be a focus of clinical attention", shows that clinicians are more aware of the frequent occurrence of religious and spiritual issues in the clinical practice[14]. It also acknowledges the importance of religion and spirituality in patient's lives (Dein, 2005). The next move should be to ensure we do not pathologize religiosity and spirituality and only pay attention to these constructs when they became part of a psychiatric problem. It would be preferable to add religiosity and spirituality to a routine assessment, and to explore them in therapy with clients, particularly those for whom meaning of life and death are at the core of their suffering, as it is the case for many suicidal people.

Webb (2003) argues that "suicidology cannot continue to turn a blind eye to the central role that spirituality often plays in the experience of and recovery from suicidality" (p. 5). I believe that some small steps have been made and that contributions like his, this manuscript and others' can help to remind Suicidologists, other people in mental health and policy makers that there is more than body and mind in everyone of us and that that "more" needs to me heard, nurtured and (re)considered in research, clinical practice and daily life.

The refuge in the transcendence, in the Nirvana,
in the marketing of the suspended states of conscience,
the dynamic of letting oneself disappear in the imagination in order to survive,
are ways to find a worldly niche of salvation from suffering the facts of the world.
(Bartocci & Eligi, 2008)

NOTES

[1] For a further discussion of the distinction between religion and spirituality, and the change in the manifestation of religion in the West, see Dein (2005).
[2] Hill and Pargament (2003) warn on the several dangers of this kind of bifurcation of religion and spirituality and observe that the sacred, in its various conceptualizations, represents the common denominator of religious and spiritual life.
[3] In this regard, Hillman (1976) observes that "the soul is a deliberately ambiguous concept resisting all definition in the same manner as do all ultimate symbols which provide the root metaphors for the systems of human thought" (p. 46).
[4] Dyson, Cobb and Forman (1997) argues that whilst experience suggests that many hold a view that art forms provide an expression of spirituality, there is a paucity of literature in support of this view, indicating an area of study that needs exploration.
[5] And probably one of the reasons why the great majority of research to date has focused on religion is because, as reported by these authors, most research has been done in United States, a very religious country.
[6] The author, however, notes that religion is sometimes discussed in Suicidology as a protective factor against suicide but comments that the emphasis is on religious taboos against suicide and the benefits of being a member of a church community whereas "spiritual needs and values as core human needs get little mention" (Webb, 2003, p. 5).
[7] The author, and I agree with him, identifies these methodologies capable of capturing the deep dimensions of human being, such as spirituality, with Constructivism and Hermeneutic-Phenomenological approaches.
[8] For a discussion about the pathologization and normalization of spiritual states and the cross-culturally common presence of mystical states se Bartocci and Dein, 2005.
[9] For instance, see Colucci, O'Connor, Perek, De Giovanelli and Minas's (under submission) study on spiritual well-being and suicide with young college students in India and Colucci's (under submission) study on spiritual/religious beliefs and suicide in young college study in Italy, India and Australia.
[10] For a critical review of theories that have postulated that existential issues of meaning in life, meaningless, and emptiness are at the heart of the suicide, an excellent reading is Orbach's (2007).
[11] A different view on this is offered by Orbach (2007), who argues that <<it is not the lack of meaning that brings about suicidal behaviour, but that mental pain is the emotional state that produces both lack of meaning as well as suicidal behaviour>> (p. 296). He highlights the role that unfulfilled needs have in this process. I believe that the lack of meaning might produce mental pain and suffering as well but I support the view that the link between needs, mental pain and meanings might be more complicated that what existential theory seem to suggest.
[12] The author also points out that the soul has been traditionally the province of the religions but in our increasingly secular society, the authority of religion has been reduced. He criticizes Western religion for not having been alert to the complexity of the inner life (emphasizing "belief" rather than interiority) and attributes to this youth's turn towards Indigenous religions or Buddhism. Webb (2003) also argues that spiritual growth is difficult in a society that is largely in denial of spirituality as a core human need.
[13] For a wider list of instruments, see the book "Measure of Religiosity" by Hill and Hood (1999) which classifies more than one hundred scales on religious development, beliefs, values, attitudes, attribution, orientation, practices, coping and problem-solving, commitment and fundamentalism. Scales on spirituality, mysticism, God concept, views of death/afterlife, forgiveness and other are represented in the book as well.
[14] This is also probably due to the fact that, as reported by the Mental Health Foundation (2006), service users, survivors and carers are adding their voices to the argument that mental heath and spirituality are intrinsically linked.

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