British Journal of Medical Psychology (1999), 72, 505–524 *Printed in Great Britain*

Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study

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An in-depth qualitative interview study is reported, with respondents ($N = 52$; all female) from the following urban-dwelling religious groups: White Christian, Pakistani Muslim, Indian Hindu, Orthodox Jewish and Afro-Caribbean Christian. Qualitative thematic analysis of open-ended interview responses revealed that the degree to which religious coping strategies were perceived to be effective in the face of depressive and schizophrenic symptoms, varied across the groups, with prayer being perceived as particularly effective among Afro-Caribbean Christian and Pakistani Muslim groups. Across all non-white groups, and also for the Jewish group, there was fear of being misunderstood by outgroup health professionals, and among Afro-Caribbean Christian and Pakistani Muslim participants, evidence of a community stigma associated with mental illness, leading to a preference for private coping strategies. The results lend further support to recent calls for ethnic-specific mental health service provision and highlight the utility of qualitative methodology for exploring the link between religion and lay beliefs about mental illness.

It has been suggested that more needs to be known about the mental beliefs of members of different cultural and social groups in order to achieve more effective liaison and help (Ball, 1995; Mitchell, 1995; Zane, Hatanka, Park & Akatsu, 1994). In particular, little is known about the nature and effects of religiously-based beliefs about the causes and cures of mental illness, and these need to be understood and taken into account in formulating appropriate care. Religious-cultural communities also tend to foster stereotypical beliefs about health professionals such as general practitioners (GPs) and social workers (Nickerson, Helms & Terrell, 1994), and a further aim is to examine how such beliefs impact on uptake and non-uptake of services. This paper reports an interview study focusing on beliefs about mental health, its causes and cures, coping and help-seeking, and stereotypes of health professionals, in five different cultural-religious groups in Britain.

Some relevant social cognitions have been studied in the general British population

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Note: An earlier version of this paper was presented at the symposium on *Religious issues in mental health among minority groups: Issues in Britain in the 1990s.* 27 November, 1996, Applied Psychology Research Group, Psychology Department, Royal Holloway, University of London, Egham, Surrey, UK

(Furnham, 1998; Kuyken, Brewin, Power and Furnham, 1992), but little is known about cultural-religious variations in such beliefs, or the relationships of such beliefs to coping strategies used in different ethnic-religious groups. Rippere, for example, has found that people do have quite complex beliefs about depression, and especially explanations and treatment strategies for their own depression (Rippere, 1977, 1979). Furthermore, Rippere (1980) argues that there is an impressive degree of consensus among her respondents when talking about depression, with, for example, broad agreement from respondents that factors such as personal dispositions, the weather, diet, sleep loss and inactivity can all be associated with an enhanced likelihood of suffering from depression. Most of these studies of lay beliefs about mental illness support Furnham's (1988) model of lay beliefs as being characterized by ambiguity, confusion, incoherence, and inconsistencies, and as theories which are typically tested inductively by verification rather than by a Popperian strategy of falsification. Unfortunately, as Furnham (1988) points out, many of these studies of lay beliefs do not explore possible reasons for individual or group differences in the structure and content of beliefs. In contrast with the large number of studies which have examined lay beliefs about the causes of mental illness, there is only a small number of studies which have examined beliefs about cures/treatments (Furnham, 1988). Of relevance to the current focus is a study by Henley & Furnham (cited in Furnham, 1988), who used a quantitative questionnaire methodology, asking respondents to rate the effectiveness of a list of 24 strategies presented to them. In terms of coping with depression, they found, using factor analytic techniques, that receiving help, having understanding, and possessing inner control were the three most important factors perceived by respondents to be associated with coping successfully with depression. In contrast, when Furnham & Henley (cited in Furnham, 1988) looked at perceptions about schizophrenia, they found that respondents stressed the physical basis of the mental illness and the need to avoid exacerbating circumstances, as well as the three factors found for depression. While studies such as those of Rippere and Furnham provide vital clues as to the nature of lay beliefs, they typically do not explore the way in which religious beliefs and practices might interact with such beliefs, and thus there remains a need for the kind of study outlined in the current paper.

There is growing evidence of a large body of religiously-based beliefs and practices in different groups, which may complement or conflict with those of orthodox medicine and psychiatry (Bhugra, 1992; El Azayem & Hedayat-Diba 1994; Littlewood & Dein, 1995; Loewenthal, 1995). To quote a few examples:

- depression may be believed to be impossible in the truly religious individual, and thus denied if it occurs;
- some religious sources may state that the devout individual should not consult a psychotherapist or similar professional since this may lead the person to irreligious ideas and practices;
- patients may use a range of religiously endorsed coping strategies and beliefs alongside orthodox psychiatric or similar help, without telling professional helpers, for fear of being misunderstood, or, for example, branded as superstitious.

There is already some evidence that the prevalence of depression and schizophrenia within the British Asian community may diverge significantly from that experienced by the Caucasian/European British population (Birchwood, Cochrane, Macmillan, Copestake,

Kuchasrska & Cariss, 1992; Thomas, Stone, Osborn, Thomas & Fisher, 1993; Williams, Bhopal & Hunt 1993). Birchwood *et al*. (1992) for example, have argued that Asian cultural practices may be a factor in the superior outcome for Asians diagnosed as schizophrenic, compared with Caucasians. This suggests that the urban British Asian community would be a useful religious-ethnic group to focus on. Similarly, North American and Israeli research suggests that Jewish, and especially orthodox Jewish, communities may manifest different rates of psychiatric disorders such as depression and psycho-somatic disorders (Levav, Kohn & Dohrenwend, 1997; Loewenthal, Goldblatt, Gorton, Lubitsh, Fellowes & Sowden, 1995). Bowling & Farquhar (1993), for example, found that Jews living in the East End of London were more likely to report problems with emotional well-being and mental health than the general population (see also Yeung & Greenwald, 1992, for North American data).

Referral rates have been suggested to be particularly low among Pakistanis in Britain (Ball, 1995; Cochrane, 1983), whereas referral may be higher among Jews than among other groups (Bowling & Farquhar, 1993; Yeung & Greenwald, 1992). Suggestions about reasons for low Pakistani referrals include fear of social stigma as a result of help-seeking, and effectiveness of support within the Muslim community. Our own work suggests that cognitive factors (particularly religious faith and prayer) are reported as important by Pakistani Muslim women in managing depression (Loewenthal, 1993), and among more strictly orthodox Jews (Loewenthal, 1995), whereas among Christians in the USA, cognitive aspects of religion have been shown to be important in coping with loss (Maton, 1989; McIntosh, Silver & Wortman, 1993). The relationship of such beliefs to coping and help-seeking remains to be examined. Studies like these continue to demonstrate the need to identify and understand the lay conceptions of mental health prevalent in ethnic/religious communities, if an adequate understanding of referral rates and help-seeking behaviours is to be attained.

Religious beliefs have been found to impact significantly on mental health and help-seeking behaviour in both Asian (Shams & Jackson, 1993) and orthodox Jewish (Bilu & Witzum, 1993; Greenberg, 1991) communities. This is congruent with meta-analytic studies and systematic reviews which continue to demonstrate a relationship between religious beliefs/practices and mental health (Batson, Schoenrade & Ventis, 1993; Worthington, Kurusu, McCullough & Sandage, 1996). These studies emphasize the need for further research which examines the interactions between ethnic and religious identities, and lay beliefs about religion and mental health.

There have been a number of investigations of social group variations in mental health (Gaminde, Uria, Padro, Querejeta & Ozamiz, 1993; Meltzer, Gill, Petticrew & Hinds, 1995); however, the potential impact of religious beliefs and practices on lay beliefs and help-seeking behaviour remains under-researched. The present paper reports selected findings from an in-depth interview study in which members of five different ethnic/religious groups were questioned on their beliefs about the causes and possible treatments of depression and schizophrenia. Our focus in this paper will be specifically on the degree to which beliefs about religion were seen to intertwine with lay beliefs about depression and schizophrenia, including the degree to which religious beliefs and practices were perceived to be a factor in interactions with professionals such as GPs or social workers. Depression and schizophrenia were chosen as mental illnesses to focus on because data exist that indicate ethnic differences in relevant referral rates. Furthermore,

previous research has highlighted that beliefs about these two conditions can be quite divergent (see Furnham, 1988). The primary aim of the study was to map some of the key group differences in beliefs about mental illness among the groups studied. A further aim was to explore the extent to which religious beliefs and practices seem to impact on beliefs about causes of, and treatments for, mental illness. We would argue that the kind of study presented is useful for at least three reasons.

1. It provides useful insights into the lay beliefs about mental illness held by different ethnic-religious groups, which can be used in the formulation of more sensitive community mental health service provision (see also Ball, 1995; Mitchell, 1995; Yeh, Takeuchi & Sue, 1994; Zane *et al*., 1994).
2. It can help to suggest possible social psychological bases for differences in referral rates. For example, Roberts & Cawthorpe (1995) in a recent British study comparing immigrants with White Europeans, found between-group differences in rates and sources of referral, family composition, diagnosis and adherence to treatment (see also Ball, 1995; Bowling & Farquhar, 1993; Cochrane, 1983; Williams *et al*., 1993; Yeung & Greenwald, 1992).
3. It can aid in the understanding of different patterns of help-seeking behaviours among groups—there is already concrete empirical evidence to suggest that the lay beliefs about mental illness endorsed by minority group members have a direct impact on help-seeking behaviours; see, for example, Ying (1990).

Method

Participants

Five groups were selected for the study on the basis of evidence from previous research suggestive of potential group differences in belief structures. Resources did not allow development of a random sampling frame, and the sampling procedure was a mix of quota (in as much as we required roughly equivalent numbers in each religious group), convenience and snowball techniques, with all participants being female volunteers. Each interviewer targeted a geographical area with a cluster of the target religious/ethnic group (for example, the Stamford Hill area of London for the Orthodox Jewish respondents), and made initial contacts through acquaintances, who then put them in contact with potential respondents (hence, a 'snowball' approach). Convenience sampling was also used, as interviewers also approached potential respondents at sites of religious worship in the target geographical areas. There were no refusals reported by interviewers. The five groups of respondents (total $N = 52$) are described in Table 1.

Table 1. Composition of respondent groups

White, Catholic ($N = 10$) Data collected in South-East England
Indian, Hindu ($N = 9$) Data collected in South-East England
Black, African & Afro-Caribbean Christian ($N = 7$) Data collected in Midlands and South-East England
Pakistani, Muslin ($N = 13$) Data collected in London
White, Orthodox Jewish ($N = 13$) Data collected in London

Note: Only female participants and interviewers were used.

Procedure

In-depth, tape-recorded interviews were conducted by interviewers from the relevant target groups, usually in participants' own homes, in either English or the relevant ethnic group's language, if preferred, and fully transcribed into English from the tapes. Where necessary, translation of interview transcripts into English was performed by the relevant interviewer. We decided to use an all-female sample for a variety of reasons: first, the researchers had found in previous studies that male members of some ethnic–religious communities are often hostile to, and suspicious of, social research on mental illness (and other topics which might be associated with community stigma); in addition, the researchers had access to experienced female interviewers from each community, who possessed the relevant language expertise and were not perceived as 'outsiders'; and finally, there is some data to suggest that, at least for depression, referral rates are often significantly higher for females. It was thought that these factors, taken as a whole, justified a focus on female participants.

The interviews were structured, following a standard schedule of open-ended questions which required minimal alteration for the different groups (only a few words needed to be changed). The schedule examined:

First half
- Perceptions of the symptoms of depression.
- Ideas about the causes of depression, including personality, religious practice (lack of), circumstances, etc.
- Ideas about possible treatments for depression, including drugs, professional help, religious beliefs and practices, friends, etc.

Second half
- The above questions were repeated, this time asking about schizophrenia.

After allowing respondents to talk about their own beliefs about the symptoms of depression, an academic definition (from Spitzer, Endicott & Robins, 1978) was provided before moving on to talk about causes and treatments (see Table 2). An identical procedure was then used in the section of the schedule dealing with schizophrenia, except that here, the academic definition was that contained in the DSM-IIIR (APA, 1987). Although not the primary focus of the current paper, academic/psychiatric definitions of depression and mental illness were used as materials, in preference to alternatives such as case vignette material, because one of our aims was to explore the degree to which lay beliefs in the groups concerned diverged from the accepted definitions and symptoms. Thus, comparison of lay with psychiatric definitions was facilitated by use of those in Table 2. Although there is a potential methodological problem in such an approach, because respondents might not fully understand the academic definitions, interviewers reported that respondents in our study did not experience any such difficulties. There is also the potential danger when using textbook definitions that respondents' fears or stereotypes about professionals, such as GPs, are primed[1]. Had a different methodology been used, such as self-completion questionnaires, it may have been more appropriate to use more informal material, such as case vignettes. In addition, it was thought that the use of case vignettes might have required the writing of a unique vignette for each participant group in the study, in order to take account of cultural differences, and this was considered to be undesirable, as comparability in materials across groups was desired in order to facilitate cross-group comparisons.

The interview schedule followed what has sometimes been called a 'funnelling' approach (Guba & Lincoln, 1981; Smith, 1995), first of all asking general questions about depression and schizophrenia which allowed the respondents' ideas to be discussed fully before moving on to the more structured and narrowly focused questions on specific causes and treatments. It was hoped that this order of questioning would go some way towards illuminating which of the causes and treatments specifically mentioned later in the schedule would be mentioned spontaneously by the participants before specific questioning.

Finally, interview transcript data were subjected to thematic qualitative analysis (for examples of this technique, see Smith, 1995) to illuminate underlying themes in respondents' talk about mental illness. This involved careful re-reading of interview transcripts for common themes and differences in the language used by each of the five groups. To start with, interviewers and researchers read over the transcripts and jointly

[1]It may be the case that respondents fear seeking help from professionals because they believe that such professionals will medicalize their distress, and there is a danger that using DSM-IIIR definitions might prime such beliefs. We would like to thank John Birtchnell for making this point to the authors.

Table 2. Definitions of mental illness used in the interview schedule

Depression (from Spitzer, Endicott & Robins, 1978)
For at least 2 weeks, the following *persistent and uncontrollable* symptoms:
1. Low mood
Plus
2. At least five of the following:
- appetite or weight loss or gain (not from dieting)
- sleep difficulty, or sleeping too much
- loss of energy
- moves slowly, or agitated movement
- loss of pleasure and interest in usual activities (such as social life, sex, work etc.)
- inappropriate guilt
- difficulty in concentration
- recurrent thoughts of death or suicide

Schizophrenia (source: APA; DSM-IIIR)
- no major mood changes (i.e. not depressed or elated)
- no evidence of organic causes (e.g. drugs, illness, injury)
- continuous signs of disturbance of 6 months duration
- deterioration in self-care, work or social relations
- for at least a week, two of the following:
- delusions
- prominent hallucinations
- incoherence or bizarre speech
- catatonic behaviour (immobile, unresponsive)
- inappropriate or no emotional responsiveness

or, one of the following:
- bizarre delusions (e.g. thoughts are being broadcast on TV)
- prominent hallucinations of a voice

agreed on a set of re-occurring themes which appeared in them, assigning them names and noting down example quotations for each theme. Additionally, those working on the coding of the data noted instances where themes seemed to co-occur and be linked to each other in some way. For our purposes, the focus in this paper will be on themes associated with perceptions about the causes and potential treatments for depression and schizophrenia, and the degree to which beliefs about religion or ethnicity related to these. Coders working on the interview data used a mix of 'grounded theory' (where as few as possible *a priori* hypotheses about the data are allowed to influence coding; see Charmaz (1995) for further discussion) and a more structured approach to identifying themes. For example, they were not guided by prior hypotheses but instead instructed to allow key themes to 'emerge' from the data, the main aim being to gain an account of our respondents' own views about mental illness. However, one also needs to appreciate that the use of a semi-structured interview schedule and textbook definitions of depression and schizophrenia does carry the danger of prompting responses which might otherwise not have emerged in a less structured encounter, and to this extent some themes must be considered to be prompted by the researchers, as we had the aim of focusing in special detail on key themes, such as perceptions of health professionals. However, the responses to such prompted themes still highlight important lay beliefs and should not be dismissed simply because they are prompted.

We will focus here on those themes which seemed to occur repeatedly, either within a specific respondent group and/or across more than one group. Furthermore, we will concentrate on the data from the minority-group respondents. The approach adopted assumes that although important contextual factors, such as the nature of the interviewer–interviewee interaction, will have an impact on the data, nevertheless the themes which emerge will provide a 'window' on the participants' world—in this case, the way in which they perceive depression, schizophrenia and mental illness. In this kind of approach, which has similarities to phenomenological (Giorgi, 1992) and symbolic interactionist (Denzin, 1992) perspectives, it is typically assumed that what participants say during interviews has some important relationship to their

underlying beliefs and values, and should therefore help in understanding behavioural intentions (see Smith, 1995).

Results and discussion

General themes in respondents' beliefs about depression and schizophrenia

Participants in all five groups did not encounter much difficulty talking about depression, and seemed to have at least some ideas about likely causes and potential treatments. It was noticeable how, when talking about both depression and schizophrenia, participants who could think of a person they knew who had suffered, or was currently suffering from, these conditions, tended to refer back to such examples frequently, and often base their responses on their interpretations and explanations of that person's problems. In the social–psychological literature on stereotypical processing, such observations would suggest that, when available, *exemplars* (i.e. salient examples) might dominate stereotypical thinking about these mental illnesses, as opposed to a reliance on *prototypical* processing (which, in contrast, would involve abstracted perceptions of the 'typical attributes' associated with a depressive or a schizophrenic; Smith and Zarate, 1990)—this is a matter for further investigation.

With depression, some participants also talked about their own experiences of depression (nine participants, 17.31% of whole sample), and many reported contact with close friends or family who had suffered from depression (31 participants, 61.54% of sample) whereas no participant indicated personal experience of schizophrenic symptoms (although 25, 48.08% of the sample, reported contact with, or knowledge of, schizophrenic family members or acquaintances). Thus, for many participants, there was a suggestion that in one sense, depressives were more 'in-group' than 'out-group', whereas the opposite was the case for perceptions of schizophrenics. This is compatible with opinion data reported by Priest, Vize, Roberts, Roberts & Tylee (1996), which indicated that in a large-scale survey of British public opinion about depression, most respondents were generally sympathetic towards sufferers. The potential consequences of a distinction between in- and out-group *vis-à-vis* depressives and schizophrenics are beyond the realms of this paper, but it is worth investigating in further research the degree to which such perceptions might be associated with in-group favouring attributional biases (e.g. Pettigrew, 1979), differences in the perceived homogeneity (see Quattrone, 1986) of depressives and schizophrenics, and other established information processing biases affecting in-group vs. out-group comparisons (see Brown, 1995, for a summary). Thus, it should be noted that the perception of certain patients as 'out-group' in turn carries with it consequences for attitudes and, ultimately, behaviour, with documented in-group versus out-group biases likely to lead to negative attitudes towards the out-group, prejudiced stereotypical beliefs, and discriminatory behaviour.

In general, respondents across all groups tended to feel that personal dispositions, stressful life events or circumstances, the weather, and loss of sleep might be causally related to depression. In terms of strategies for coping with depression, there was greater heterogeneity between the groups in the study, with some feeling that religious practices and beliefs might help, but all tending to feel that support from friends and family, and removal of environmental stressors, would facilitate recovery. Beliefs about schizophrenia were much more heterogeneous, with respondents being rather reluctant to forward their own ideas once

they had been introduced to the 'official' DSM-IIIR description of schizophrenic symptoms, and fewer respondents believing that prayer could help. This may have been because participants' lay understandings of schizophrenic symptoms were divergent from those outlined in the official description, and awareness of this difference may have reduced the confidence of respondents to outline their own idiosyncratic ideas and theories. In general though, respondents in all groups felt that schizophrenia was more serious, more likely to be associated with organic problems, more likely to be hereditary, and less controllable by the patient, compared with depression. Participants felt that schizophrenia was more likely to require professional help, and that religion was less relevant as a coping strategy.

These differences in lay perceptions of the causes and cures of depression vs. schizophrenia are congruent with those of Henley & Furnham, and Furnham & Henley (both cited in Furnham, 1988). They suggest a tendency for the public to perceive schizophrenic symptoms to be indicative of a more serious underlying disorder than depression, and one which may demand treatment strategies outside of the control of the patient. Thus, it could be said that when talking about depression, respondents appeared to manifest a more internal locus of control (Rotter, 1954), in comparison to when they talked about schizophrenia, when their locus of control appeared to be more external (for both perceptions of causes and treatments).

Contact with professionals, such as GPs, social workers and psychiatrists

Most respondents felt that a psychiatrist would be an appropriate professional to seek help from, both for depression and schizophrenia (for each disorder, 41 respondents, 78.85% of the sample, believed that a psychiatrist could provide useful help). However, there was fairly widespread ignorance as to the techniques psychiatrists might employ, and little understanding of the differences between psychiatrists, psychotherapists and psychologists. These observations are compatible with Furnham's (1988) observations about the general ignorance of the public about psychiatry.

In contrast, respondents felt that although they would probably approach their own GP for help (for both depression and schizophrenia, 30 respondents said they would approach their GP, 57.69% of the sample), he or she would probably do little more than either refer them on to someone else, or prescribe them some kind of drug. This result again seems compatible with Priest *et al.*'s data, which indicated that, at least among the British public, there is a reluctance to consult when faced with depressive symptoms (Priest *et al.* 1996). A common theme which emerged when talking about GPs was the belief that they have very little time to talk through patient problems with them, and to help them try to deal with stressful life events. As such, a GP tended not to be seen as someone one could turn to if all one wanted was a good listener. There was therefore some evidence for a shared stereotype of GPs which characterized them as generally caring and philanthropic, but over-worked, stressed and likely to rely on prescribing drugs as a treatment for mental illness. The latter belief may discourage those suffering depressive symptoms from consulting their GP, as there is evidence for negative attitudes towards antidepressants (Priest *et al.*, 1996). For example:

> I don't know, I really don't know how he would help me. They normally just give you tablets and tell you to go away anyway don't they?. . . to me that's no answer, I think you need someone to listen, you know? (Black R1)

> . . .unfortunately, the thing with GPs is that they don't have much time on their hands. . . they're not really all that excellent at listening to personal problems. . . (Black R3)

> I don't know if the doctor has the time to actually help, they're under a lot of stress as it is. Can they really go round and help them? Except for maybe spend fifteen minutes, they're under a lot of stress. . . (Hindu R1)

For schizophrenia, respondents again felt that the GP was a person they were likely to approach, however the feeling was that with such a serious condition, he or she would lack expert knowledge and simply refer one to a specialist.

On preferring a professional of the same race or religion

Participants were questioned specifically on this issue both in relation to seeking treatment for depression and for schizophrenia. The issue of ethnic and religious matching of therapist and patient is a central one in the formulation of culturally-sensitive mental health service provision. We would suggest that ethnic and religious beliefs and identities will intertwine to jointly affect attitudes towards professionals associated with mental health, such as GPs and psychiatrists. Thus, an important aspect of lay beliefs about mental illness are the associated beliefs concerning encounters with professionals, especially as such beliefs are likely to have an impact on actual help-seeking strategies adopted, and the extent to which professional–client encounters proceed smoothly. Overall, 48 respondents (92.31% of the sample) felt that it could be beneficial to seek help from a professional of the same race and/or religion.

For the African/Afro-Caribbean group (four participants would prefer an own race/religion professional; 57.14% of that subgroup), race was the primary issue here, rather than religion, with individuals feeling that a black professional might be more sympathetic and understanding of a black patient/client:

> It's only natural because birds of the same feather. . . I think you feel more confident that you're trying to relate the problem to someone culturally and emotionally and all that. . . (Black R2)

> . . .going to hospital for therapy, talking on a one-to-one with people as a Black person I find it very difficult because I can't really, they can't relate to some of the things that are going on in my head, and I can see that they can't and that frustrates me. If I was sitting and talking to a Black person every now and then I'd break into a little piece of patois and I know she can understand me. . . but there wasn't anybody I felt I could identify with or who could identify with my particular problems. . . there were the things on the periphery like the lads {her two sons}. . . and my mortgage and stuff like that, yeah, they could deal with stuff like that, but the deep-seated things you're not able to talk to them about it because you know they won't understand, so it would help if more Black people were within the mental health system. (Black, R4)

In the discourse of black participant R4 above, the language of in-group versus out-group is evident—'as a black person', 'they can't relate', 'identify with', 'they won't understand'. Clearly, this respondent is pessimistic about the chances of being understood and treated in a non-prejudiced manner by health professionals. Unfortunately, when such fears are present, they can unwittingly result in a self-fulfilling prophecy effect, even in encounters with those who genuinely strive to practice in a non-prejudiced manner, due, for example, to such things as 'leakage' of expectations, both verbally and non-verbally (for examples see Jussim, 1986, and Snyder, 1984).

For the orthodox Jewish sample, 10 participants (76.92% of that subgroup) felt that it would be preferable to see an orthodox Jewish professional, again, like the Black Christians, feeling that such a professional would understand the socio-cultural milieu in which the clients live and perhaps also the unique pressures facing Jewish mothers. Furthermore, there was a feeling that an orthodox Jewish professional would also understand better the specific manifestations of depressive symptoms with which an orthodox Jewish client might present, and the underlying fear that a non-Jewish professional might misunderstand an orthodox Jewish client:

> For a frum {Orthodox Jewish} person, I'm sure it would {make a difference if the professional were frum}. . .Because then they're on the same wavelength aren't they? If you start telling a non-Jewish or non-frum person about the way you feel and they'll think you are a little bit. . .they just wouldn't. . .I think a frum person couldn't relate to a non-frum person, a non-frum psychiatrist or someone. (Orthodox Jewish, R2)

> . . .a non-Jewish person just wouldn't understand things about Hashem, or faith. The concentration camps, whatever. All sorts of pressures that Jewish people have in their house that non-Jewish people just don't understand. . . (Orthodox Jewish, R5)

However, it emerged that for some groups, the feeling was that having a professional of the same race or religion was a double-edged sword, because one wanted to be understood and feel affinity or a sense of shared identity with the professional, but at the same time an own-race/religion professional ran the risk that news of the consultation might somehow leak back to the community, resulting in stigma and embarrassment for one's family. For example:

> . . .some Jewish people might say 'Oh I don't want this to be known within my community'. . .There's also an understanding. . .one may feel that there's an understanding if this is an orthodox person, there is an understanding to the background. . . (Jewish, R4)

This fear was also articulated by Muslim participants:

> Although they will be able to talk to such a person, at the same time they will be afraid of him, so reassurance of confidentiality is very, very important. (Muslim, R9)

All of the Muslim participants indicated a preference for professionals of the same race, and also for Muslim professionals, even when seeking help for schizophrenic symptoms (13 respondents; 100%):

> I think our depression is different to a white person because our circumstances are different. Our personality is different, our family background is different. . . (Muslim, R10)

One way, for example, in which the Muslim respondents felt another Muslim might help, is by suggesting ways in which particular religious practices might help, such as specific readings from religious texts.

Like the Muslim group, all nine of the Hindu resondents reported a preference for professionals of the same religion, again referring to the themes of shared cultural understanding and common identity:

> Yeah. . .from the same ethnic origin that would definitely help, because they'd know exactly what the problem would be and how it would be explained and the reasons for it. . .I can't see how. . .if it's a

> different ethnic. . .like I'm Hindu and if that person went to a white or another origin, I can't see how they would fully understand that person. . .I can't see how they can fully understand the background and the culture of it. . .They might think that because he's black or Asian they might put him into an institute {talking now about schizophrenia later in the interview}, whereas the others might have more help. . .it does. . .it has happened, maybe, I'm not sure. . . (Hindu, R2)

> . . .if you're going through family problems or problems with your in-laws, I don't think the white generation would understand that because they don't go through the same kind of things. A Hindu person would understand what the problem is. . . (Hindu, R5)

Thus, there was evidence from all of the non-white groups in the study, to suggest a common fear of being misunderstood by professionals from outside the group.

Religion as a cause of depression and schizophrenia

About one-third of all participants in the study felt that religion could actually play a causal role in depression (18, 34.62% of the sample) and fewer still in causing schizophrenia (eight participants, 15.38% of the sample). The participants were mostly in the Muslim group (six Muslims believed in religious causes for depression, five for schizophrenia: 46.15% and 38.46% of the Muslim subgroup, respectively). They felt that depression, and to an extent schizophrenia, might partly be caused in Muslims by lack of faith and failure to pray regularly. However, two-thirds of the sample (34 participants, 65.38%) felt that religion is not relevant to an understanding of the causes of either condition. In contrast, over two-thirds of participants believed that religious beliefs and practices could play a useful role as a treatment for depression and schizophrenia: 42 said that prayer was a useful treatment for depression (80.77% of the sample), and 31 said it was a useful treatment for schizophrenia (59.62% of the sample).

Prayer as a treatment for depression and schizophrenia

The group in which there was the most agreement that religion could help treat depression and schizophrenia was the Muslim group, where 12 (92.31% of the subgroup) felt that it could help depression, and nine (75%) thought that it could help with schizophrenia. For example:

> . . .In our teaching, when we have a problem we concentrate on it and talk to Allah about it and ask for help from Him. When someone has faith in Allah and talks to Him about a problem it lifts all sorrow and gloomy moods because the person is sure that Allah knows they have asked for help, and He will help them. It brings positiveness in life. If someone doesn't have all this they will be depressed for sure. (Muslim, R8)

> It does not matter how depressed you are, if one can divert your attention towards prayer, the feeling of helplessness and loneliness can disappear. . .giving all problems to Allah and having faith in Him is very therapeutic. (Muslim, R9)

For both of these respondents, there is a confidence that Allah will listen to requests for help in their prayers and act upon them, and this knowledge seems to bring a sense of comfort. The second extract, from Muslim participant R9, also highlights a theme which

occurred in the responses from other groups: the notion that prayer can be helpful because it presents an opportunity to off-load responsibility for dealing with one's troubles onto God. For example, talking about prayer as a treatment, one Caribbean respondent commented:

> . . .it's almost as if you've given the problem to God and you no longer have to deal with it. . . (Black, R4)

Another theme associated with beliefs about prayer was the idea that (private) prayer is useful because it also allows one to keep any mental health problems hidden from the community, one's family and so on:

> Well I think if you know there's a God that's there listening to your prayers, OK you won't get a response, but just by talking to Him I think it helps, yeah, and you know He's there. . .He's always going to be there for you and *He's not going to tell nobody your business*. . .I know when I'm feeling a bit down I pray and I feel better by just praying. (Black, R1; our emphasis)

Furthermore, prayer was sometimes perceived to be a means of gaining better inner knowledge about oneself, as almost a form of self-administered therapy, and as such, something valuable because feelings of control and self-efficacy were maintained. The apparent contradiction between these beliefs and the idea of giving one's problems over to God to deal with (which seems to reduce perceived control and self-efficacy) did not seem to be apparent to respondents. In addition, prayer was seen as less inhibiting than talking to friends, relatives, or professionals—respondents felt that they could say whatever they felt like in prayer.

> . . .because you're speaking to somebody who isn't physically there, you feel you have no bounds to what you say, you can say what you say. . .you feel you're speaking to somebody. . .who knows you better probably, better than you know yourself, so you don't feel ashamed. (Black, R3)

Those Afro-Caribbean participants who manifested a strong belief in the utility of prayer (six, 85.71% for depression; five, 71.43% for schizophrenia) demonstrated very high levels of confidence that prayer would work and that God or Jesus would always listen. This confidence in God was something that Afro-Caribbean respondents shared with Muslim respondents in the study, and both valued prayer particularly for its private nature. Unlike consultations with professionals such as GPs, prayer, for Muslim and Afro-Caribbean respondents was something that they felt very comfortable with, and with which they did not associate the possibility of being misunderstood or discriminated against.

In addition, it also seems likely that the confidence Afro-Caribbeans had that their prayers would be answered, which was also seen with a few orthodox Jewish respondents, is likely to lead to such participants developing positive cognitions about their own futures, and to protect self-esteem from some of the dangers of depression. In the social psychological literature on the self-concept, it has been argued that individuals develop mental 'scenarios' of both desired and feared possible futures (what Markus and Nurius, 1986, call 'possible selves'). It could be argued that those participants in our study who have a lot of confidence in the efficacy of prayer, might have more positive possible selves when they are faced with mental health problems, and this might impact on both choice of coping strategies and the efficacy of any such strategies:

> I pray and ask the Lord to help me to bear things as they come and I don't get depressed over them, and He helps me and I'm fine. . .I know He's there to help me. . .you'll find all the peace and all the happiness you want if you just turn to the Lord, you have no fear, no fear whatsoever while the Lord is near you. . .Now if somebody's depressed and they don't know what to do, you know what I would do? I would pray with them, and tell them about Jesus and what the Lord can do for them. . .I can give {prayer as a treatment for depression} a hundred out of a hundred because there's nothing greater than prayer, it's great. . . (Black, R5)

This same participant had developed a strategy for dealing with occasions when it seemed that prayers had not been answered. In such situations, she believed that the prayers were being answered, but sometimes in subtle, mysterious ways:

> He did it His way. . .the Lord knows when the right time is. . .and he has a reason for everything, but we don't know. . . (Black, R5)

A related strategy for dealing with the apparent failure of prayer was evident from one Muslim participant, who suggested that '. . .the Quran will help you and religion will protect you. . .it will save you *if the person is a good practising Muslin*. . .' (Muslim R1, our emphasis). One danger with this kind of belief is what it implies about those who do fall prey to mental illness; as another respondent put it, '. . .good Muslims will not slip into deep depression.' (Muslim, R3), which implies that the mentally ill may therefore be perceived to be 'bad' Muslims, which is perhaps one of the primary causes of community stigma over mental illness. This is also a risky belief to adopt if the person holding it comes to realize that they themselves, or family members, are suffering from mental illness. Here, however, some participants felt again that their Muslim faith held the answer—it is 'God's will', which at least provides the comfort of knowing that it is not meaningless, that one is suffering from mental illness for some (albeit spiritual) reason.

Opinions about seeking help from holy persons

Across the sample as a whole, about one-half of all participants felt that it would be useful to see a holy person if suffering from depression (29 participants, 55.77% of the sample), and slightly fewer thought that a holy person might help if experiencing schizophrenic symptoms (27 respondents, 51.92% of the sample).

Orthodox Jewish participants tended to be rather ambivalent about the utility of consulting a Rabbi, with some feeling that it very much depends on the personality of the Rabbi, and others feeling that religion might prevent them being sympathetic or understanding their problems. For example:

> Personally I would first consult a person who is non-religious. If I felt that they didn't understand the religious context I might switch if I thought it was a problem. (Jewish, R7)

The Muslim group, perhaps more than any other group in the sample, felt that religion could be a source of treatment for mental illness, yet even these Muslim participants were not enthusiastic about seeking help from a holy person, preferring instead to stress the utility of private prayer (two Muslims, 15.38% of the subgroup said that a Holy person could help with depression, and four said that a Holy person could help with schizophrenia, 30.77% of the subgroup). For example:

> In our religion we don't need a person to take our religious responsibilities, nothing like the Pope, or

> Archbishop, or Brahman, or Rabbi. Every one of us is responsible to learn whatever we can by ourselves, and are answerable to God for it. . .in our religion we can talk to God directly, we don't need help from anyone. . . (Muslim, R9)

Another theme in the Muslim responses, and one which also appeared in the Hindu responses, was the feeling that certain elements of the communities concerned (but not the participant themselves) might wish to visit a holy person, perhaps because they did so 'back home' or still believe that mental illness is spiritual in origin:

> . . .{if their family} back home is like that and they believe in holy man and things like that. . .but educated people will avoid this. (Muslim, R5)

> . . .probably in the older generation if you've got a mental illness, they think you've got a bad spirit in you that's why you hear all these voices and that's why this person is telling you to do things you've been doing {talking about schizophrenics hearing voices}. . .they'll just think, 'oh, go to a holy person and they will cure you'. If you talk to my generation they will probably know that it is something different. . . (Hindu R4, aged 19)

There was thus a feeling that there might be inter-generational differences among the two Asian communities included in the study, with younger respondents feeling that older members of the community might adopt more religious explanantions of mental illness, as well as prefer religious coping strategies more, compared with younger members. Two additional themes to emerge were, first, that some 'traditional' families might exert pressure on family members to see a holy person, and second, that one advantage about seeing a holy person is that this is not in itself, associated with stigma, whereas seeking help from a GP or psychiatrist is more risky in terms of community stigma.

Community stigma

Evidence emerged that some groups in the study do seem to perceive that their exists stigma in their corresponding communities, serving to make life difficult for individuals and families associated with the label of mental illness. For example, an orthodox Jewish participant seemed to hint that she would not welcome being told by her GP that she was depressed, perhaps precisely because of the community stigma associated with mental illness:

> . . .it takes a lot of *courage* to go {to your GP} and say 'I'm not feeling very well. . .Perhaps to be. . .to be told to your *disgust* your GP says that you might be depressed, and that can knock a person sideways as well. . . (Orthodox Jewish, R4, our emphasis)

This respondent clearly appears to fear the act of being labelled 'depressed', presumably because of negative consequences for both self-identity and community reputation, and it appears that she would probably prefer mental health problems to be given less threatening labels. In contrast, another orthodox Jewish participant felt that there was no longer any stigma attached to depression in the community, but that there is still stigma attached to families when members are incarcerated or reside in institutions as a result of mental health problems. Thus, it appeared that there was heterogeneity within the Orthodox Jewish group, concerning beliefs about mental illness and stigma.

One other group in which participants seemed aware of community stigma was the African/Afro-Caribbean group, where again, the theme was largely tied to fear concerning family reputation within the community:

> . . .the thing is, if people can identify you as someone being depressed, I think it's even going to make it worse because in a way they tend to be rejected. . . (Black, R2)

> There tends to be a taboo about mental illness in Black families to start with so they wouldn't be seeking help from friends, they would probably want to go to their GP and for the rule of confidentiality to apply all the way around. The one thing Black people hate is for anybody to find out that there is any form of mental illness in their families. . .it's the old taboo subject—somebody's mentally ill in your family, as a Black family you just don't go shouting about it. . .what they try to do is shut that person away and deal with it by themselves as opposed to going through all the networks and being exposed. (Black, R4)

The comments of this Black participant (Black, R4) highlight how talk about mental illness is intertwined with a concern for confidentiality and a fear of community stigma—note the use of words such as 'taboo', 'confidentiality', 'exposed'. This is probably reflective of the same syndrome that Muslims experienced, revolving around a fear of being 'doubly stigmatized' by one's own ethnic/religious group (for being mentally ill) and by white-majority society (for being non-white). In addition, as the Afro-Caribbean and Muslim participants tended to live in geographically identifiable communities, there was a sense in which maintenance of family and individual 'reputations' within the community was a key consideration.

One unfortunate aspect of these fears of community stigma, is that they can reduce the likelihood that individuals from such ethnic and religious groups will turn to other community members for help and advice. For example, one orthodox Jewish participant suggested that there existed pressure within the community to promulgate the image of being a good mother, and that this could cause Jewish mothers to avoid seeking help when suffering from post-natal depression. The implication here was that being seen to seek help for post-natal depression might be perceived to indicate failure to cope with the demands of motherhood.

In a similar manner, Muslim respondents suggested that being known to seek professional help is seen as a sign of weakness by other members of the community, and as such has undesirable effects on one's reputation:

> . . .our people do not {go to the Doctor when depressed}, in fact they hide it because they think that if people know about it they will not accept them and they'll be laughed at and would be completely shut off because there is this prejudice. (Muslim, R7)

> Younger people will accept this but the older members of the community and men do not believe that depression exists. They say a woman is just making it up, she is just a housewife and has nothing better to do. (Muslim, R8)

Furthermore, one Muslim participant felt that the white community has rejected her community, and that this leaves Asians especially concerned not to be rejected by their own community as well, and thus may reduce the likelihood that they seek help. This suggests that where ethnic minorities feel stigmatized by the majority group, then this might make fear of community stigma especially intense. Coupled with these fears of

community stigma were concerns about the possible effects of such stigma on one's children and family. In ethnic–religious communities which encourage arranged marriages within the same community, it seems likely that this fear of community stigma will be particularly intense, at least for those who adopt the norms of the community. For example:

> If a person goes to one of these professionals {a psychotherapist/psychologist or social worker} they might be concerned that if somebody in the community finds out they will be labelled as mad and their family will become outcasts. . .In this country the community is so close that individuals are afraid of it having an adverse effect on their relationship as well. (Muslim, R5)

> . . .when somebody says, 'I'm sending you to a psychiatrist', I would think 'am I really gone mad?' and that lowers your confidence. People think I am mad so I am not useful anymore. . . (Muslim, R10)

> . . .we are afraid that the community will find out. . .there is a fear in our nature that other people will find out. These are our problems so we should keep our problems to ourselves. In our society if it is known that in some household there is a mental problem then the biggest problem will be of finding a match for the children. . .This is the way we were brought up. . . (Muslim, R9)

Combined with this fear of community stigma in the Muslim group, was the feeling that some Muslim families believe that family problems should be kept private and dealt with within the families concerned, rather than seeking help from friends within the community. For example:

> When we are growing up back home it is taught that we should not talk about our family problems to anybody outside the house. . .no problem should go outside. (Muslim, R2)

Having outlined the kind of community stigma feared by many Muslim participants in our study, it becomes clear why the private nature of prayer is particularly valued by participants in this group, and why there might be a reluctance to seek help from friends and advisors within the community, when faced with mental health problems.

Conclusions

Before considering the implications of the lay beliefs highlighted in this study, it is worth noting that various methodological issues should be considered in such an evaluation. First, it must be remembered that only female members of the five groups participated, and we can not assume that the lay beliefs which emerged would not be affected by sex differences—this remains an issue for future research. However, there are good reasons for focusing on female respondents (see earlier discussion in participants), not least because women are often the carers for the mentally ill, and as such are crucial in the initial stages of identifying mental illness in the family[2]. Second, this study was of an exploratory nature—resources did not allow large, representative probability samples to be used, and given the modest sample sizes, the data must be considered as essentially suggestive of possible group differences. Nevertheless, it is compelling that many of the lay beliefs emerging out of the data overlap with those found by other researchers investigating similar domains (e.g. Furnham, 1988, Rippere, 1977, 1979, 1980). Furthermore, we

[2]The authors would like to thank an anonymous reviewer for making this point to them.

would suggest that the kind of qualitative thematic approach adopted in the current study, an approach which is particularly useful for the analysis of in-depth interview data, should be seen as an essential complement to more quantitative, large-scale survey methods. The latter, due to their very nature, are not well-suited to the detailed evaluation of discourse, but can, to a limited extent, explore the causal processes which might impact upon belief systems, using multivariate statistical techniques. Thus, for example, in the present study strength of religious belief was not measured, because no quantitative measures were administered, and this means that we can not discount the possibility that such a variable might have an impact on the kind of beliefs which emerged in our own data[3]. Nevertheless, the kind of in-depth qualitative approach adopted here, allows the researcher to investigate the underlying structure which lies behind attitudes and belief systems, something which fixed-response attitude scales used in large social surveys are not particularly sensitive to.

Turning now to our data, it can be noted from the qualitative observations presented earlier that participants' lay beliefs about depression and schizophrenia did seem to fit the general model of lay beliefs forwarded by Furnham (1988). Beliefs about depression and schizophrenia were seen to be ambiguous, contradictory, and subject to confirmation through personal experience rather than tested via falsification. However, unlike previous studies, it has also been demonstrated that religious affiliation intertwines with ethnic origin to result in some important differences in the beliefs prevalent in different ethnic and religious communities in Britain. In terms of religion, it emerged that the African/Afro-Caribbean and Muslim participants in particular felt that religion did have an impact on their choice of strategies for dealing with depression. Furthermore, both of these groups indicated a fear of community stigma associated with mental illness or, more worryingly, even the act of seeking help, which must surely have an impact on actual coping strategies and help-seeking behaviours. In terms of help-seeking behaviours, the current study has also highlighted a tendency for members of some ethnic/religious communities to prefer consultations with professionals of the same background. Here, fear of being misunderstood due to ignorance of cultural and religious practices (Loewenthal, 1995), intertwines in a complex fashion with a fear of being the target of racism, and a general feeling that it is easier to talk to professionals with whom one shares a common ingroup identity.

The results are therefore broadly compatible with recent calls for ethnic-specific mental health provision (e.g. Vega & Rumbaut, 1991; Zane *et al.*, 1994), but also raise the issue of whether such provision also needs to take religious beliefs into consideration (Greenberg, 1991). At the very least our results suggest the utility of exploring the way in which religious beliefs and practices in minority groups relate to beliefs about mental illness. One good reason for doing so is that the data suggest that such beliefs are likely to have a profound impact on help-seeking behaviours and treatment strategies. The kind of qualitative enquiry used in our study would also provide a useful starting point for the gathering of information which might help to inform cultural awareness interventions aimed at improving the delivery of mental health services to members of minority ethnic and religious communities (see Bilu & Witzum, 1993; Kim, 1989).

[3]The authors would like to thank an anonymous reviewer for making this point to them.

Acknowledgements

This study was partly funded by awards made to the authors by the University of London Central Research Fund, and the Psychology Department, Royal Holloway, University of London. The authors are grateful for all the hard work put in by our interviewers: Nicola Cox, Vivien Goldblatt, Hanifa Khan, Emma Lowers, Paul McGowan and Neeshma Vesuwala. The authors would like to thank John Birtchnell and three anonymous reviewers for useful comments on an earlier draft of this paper.

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Received 20 January 1998; revised version received 24 September 1998