'Religion, Spirituality and Psychiatry'

Dr. Mohamed Omar Salem

Introduction:

Religion is an important constituent of culture or the way of life of a society. Man's faith is as old as humankind itself. Priests and physicians were often the same individuals in different civilizations (Bhugra 1996).

For a considerable time, psychologists and psychiatrists have largely neglected this important area of human experience. Over the last few years, however, a substantial number of studies have been increasingly seen in the psychological and psychiatric literature relating to religion and mental health (Dein et al. 1998).

In his Presidential Valedictory Lecture, Sims (1994) criticized psychiatrists when they ignored the spiritual dimension of their patients. He emphasized the need of psychiatrists to understand their patients who often take spiritual issues seriously. He gave an example of a patient with schizophrenia who heard regularly a voice commanding him to jump out of the window. According to the advice of his mother, he has been able, for some time, to resist this impulse by praying to God. So, his mind was damaged, but his capacity for spiritual life was still present (Sims & O'Brien 1979).

Recently, the Trainee Committee of the Royal College of Psychiatrists has recognized the need to consider spiritual issues. The Committee emphasized the importance of the *physical, mental* and *spiritual* aspects of healing in the training of doctors in general and psychiatrists in particular Kehoe et al, 1992).

According to one survey of clinical psychologists, 60% of clients often express themselves in religious language (Shafranske & Malony, 1990).

Pragment argues that, the therapist comes to the relationship grounded by a set of basic assumptions about people, life and helping. Drawing on this 'orienting system', the therapist tries to assist others. He believed that therapy in this sense involves a meeting of two worlds, and this meeting is far from being a value-free encounter (Pragment, 1997).

Also, Sims rejected the idea of the psychiatrist as being totally reflexive, and considered it ill conceived and outdated. He believes that there is no such thing as 'valueless' psychiatry; all of us, as we practice, carry our values, standards, aims and goals from the rest of life into our psychiatry, and the same apply to our patients. However, we do not try to impose our own values on our patients, yet the psychiatrist cannot abrogate his own moral responsibility to evaluate each situation and apply his own values (Sims, 1994).

According to some studies, counsellors affect the goals for therapy (Worthington & Scott, 1983), 'influence their clients' values over the course of counselling, and selectively attend to and overlook what their clients are saying (Kelly, 1990).

Some surveys have shown that mental health professionals, especially psychologists, are less involved in traditional religious practices than those they serve (Ragan et al, 1980: Shafranske & Gorsuch, 1984).

On the basis of these findings, concerns have been raised that therapists, knowingly or unknowingly, may 'convert' their clients to a secular value position (Tjelveit, 1986). In the USA, some religious adherents have charged psychologists with disregard or derogation of religious and spiritual dimensions (Pragment, 1997). However, more recent surveys suggest that the 'religiosity gap' between therapist and client may be narrowing (Bergin and Jensen, 1990; Shafranske and Malony, 1990).

Definitions:

Speck (1997) argued that we need to distinguish between spirituality and religiosity. The former refers to an experience of contact with a higher power, whereas the latter also includes the outward framework for religious experience.

Indeed, the vast majority of research today that talks about spirituality and its effects on health, in reality examines only religion (Shams & Jackson, 1993).

Sims (1994) mentioned five aspects of spirituality to be considered by the psychiatrist. They included looking for *Meaning in Life*, *Human Solidarity, Wholeness of the Person*: being body, mind and spirit, *Moral Aspects*: what is seen as good, as opposed to what is seen as bad, and *Awareness of God*: the connection between God and man.

Intrinsic religiosity implies taking the teachings of religion seriously, while extrinsic religiosity involves a 'selfish and instrumental' use of religion (Hunt & King, 1972). Batson *et al.* (1993) suggested a positive relationship between intrinsic religiosity and a number of measures of mental health, while extrinsic religiosity related to poor mental health.

Generally, the concept of 'religion' discussed in this paper is based on the established traditional religions, and excludes abnormal religious cults and deviant religious groups.

Psychological functions of Religion:

Religion can be a major source of ego support. Life is difficult and the world presents an unpredictable and risky environment. The complexities of modern life make such a statement even more obvious. Religion, usually including a community of shared beliefs, offers support and structure for coping with such stressful inevitable events. It may also enhance positive experiences, such as hope and optimism.

The following are examples of common stressors for which religious support is quite appropriate:

1) Birth and Death

We welcome the neonate with a sense of renewal and religious joy. Most religions include rituals as circumcision, baptism, azaan, akika and blessings for acknowledging the birth and helping to ensure the health and welfare of the new arrival.

Confronting death is another major function of religion. Funerals, wakes and interment are the events for which religious support is usually sought. Families are comforted and consoled at this time of greatest suffering. All can

unite around shared religious symbols and rites to focus on the life of the deceased, to ponder the meaning and purpose of life and death, and to help the bereaved endure the pain of their immense loss.

2) Life Passages:

Developmental life passages are ritualistically recognized by religion. The transition from childhood to adolescence with the arrival of puberty is given special attention by all religions. Underlying concerns about emerging sexuality and aggressive drives may be more comfortably focused and controlled, and a more socially responsible role acknowledged by these events.

3) Marriage:

The new life of the couple and the birth of the new family established has been traditionally under the regulations and blessing of the religious system. A blending of cultural and religious traditions is well exemplified in the wedding ceremony. Studies have shown that religiously active marriages are more satisfying and less prone to divorce. (Roth 1988, Dudley & Kosinski 1990)

4) Child Rearing:

Religion is usually seen as a necessary part of the moral and ethical education of young children. New parents feel a need to train their offspring in the ways of their own religious experience. Religious families instil religious values in children, stressing commitment and character development, including honour and respect of parents.

5) Ageing

Religious elderly populations usually adapt well to aging. This is the time when they hope to end their life record with satisfactory religious activities and commitment. On the other hand, reduction in religious faith, which may result in an existential crisis, often produces uncertainty and anxiety in the elderly.

6) Life Meaning:

Religion can provide a source of explanation and understanding of questions such as the meaning of life and death. Many authors, including Frankl (1965), and Peck (1988) have emphasized the importance of searching for life meaning. Frankl commented on the despair of those living in an 'existential vacuum'. He believed that frantic efforts to combat boredom and a sense of emptiness through sexual encounters and other means are futile.

7) Life events:

Accidents, death, and a certain degree of pain, suffering, and loss in life are unavoidable. Religion can provide a source of comfort, explanation and meaning for individuals when faced by such crises in their lives. Prayers for strength, patience and forbearance are offered to the victims. This is particularly seen at time of war and following natural disasters, when both civilian and military populations seek out religious support.

Sociological aspects of religion:

Religion has an important role in **social integration and control**. Religion is part of the culture or way of life of a society, and it helps to maintain cultural traditions. Society can only survive if people share some common beliefs about right and wrong behaviour. Durkheim saw religion as a kind of social glue, binding society together and integrating individuals into it by encouraging them to accept basic social values. So, it is mainly through religion that an individual is socialized into the values of the society. This set of moral beliefs and values may have been so deeply ingrained through socialization that it may have an effect on the everyday behaviour of believers and non-believers alike. If some rule is broken, most individuals will experience a guilty conscience about doing something 'wrong', and this is a powerful socializing and controlling influence over the individual.

Another important sociological function of religion is **social support.** Religious doctrines encourage positive social attitudes and self-sacrifice. Studies have shown that religiosity is strongly related to almost every dimension of social support. In the USA, one study confirmed that support for the elderly from church members exceeds that from all other sources combined. Social support in turn is related to lower rates of depression, anxiety, loneliness, and other mental health problems. Indeed, emotional support from others is a major therapeutic tool used in all forms of counselling and psychotherapy (Browne, 1998).

Religion and Mental Health:

During the past half-century, especially the last twenty years, a number of well-designed studies have examined the relationship between mental health and religious belief, commitment or practice. The following is a review of some of them.

1) Coping with stress, and Adjustment Disorders:

Several studies (Bergin 1983, Koenig 1988, 1994, 1996,) examined coping strategies among different populations including persons facing serious health problems, or in the midst of severe life stress - concluding that religion (faith in God, prayer, scripture reading, or attending church, mosque or synagogue) was the important factor that enabled them to cope with difficult or stressful life circumstances.

Other studies (Loewenthal 1995, Dein 1996, Worthington et al 1996) have suggested that, religion buffers the effects of stress, leading to lowered distress, compared with those low on religious resources.

In a large study Koenig and his colleagues at Duke University Medical Centre in North Carolina (1992) examined the relationship between the use of religion as a coping behaviour and depression in a sample of almost 1,000 hospitalised medically ill men. People who used religion as a coping behaviour were compared with those who said they coped in other ways (staying busy, visiting friends or family, and so forth). Patients who depended heavily on their religious faith to cope were significantly less depressed than those who did not. Two hundred and two patients were then followed up for an average of six month after they were discharged from hospital. The objective was to determine what characteristics of patients at study entry

would predict who later became depressed. The only characteristic that predicted lower rates of depression was *not* the level of support from family or friends, *not* physical health status, and *not* even income or education level but rather the extent to which patients relied on their religious faith to cope. This was the only factor that predicted significantly better mental health six month later.

2) Religion and Life Satisfaction:

Although health professionals seem to be less interested in positive states of mind than in mental disorders, several studies reported positive association between religious commitment and well-being among persons of all ages (Koenig et al 1988, Levin et al 1988, Koenig et al. 1995, Ellison et al 1989, Ellison 1991).

Other investigators have also found a positive association between religion and happiness (Poloma and Pendleton 1990, Robbins and Francis 1996, Lewis and Joseph 1995).

Satisfaction with life is thought to be a cognitive aspect of happiness. Examining a national sample of black Americans, Jeffrey Levin and colleagues (1994) found that persons who were more religiously involved experienced significantly greater life satisfaction, even after taking into account the effects of physical health status and other conventional predictors of well-being.

In a very recent publication Dorahy and his colleagues (1998) examined the relationship between religiosity and life satisfaction across four cultural groups. A general finding in their data was the positive association between religion and life satisfaction across gender and cultural groups. Ellison (1991), among others, has suggested that the cognitive aspects of religion - which offer a stable existential view of the world, have the greatest effect on life satisfaction.

3) Anxiety:

In a large study examining the relationship between anxiety and religious activity in a sample of almost 3000 persons, it was found that people with religious commitment experienced significantly lower rates of anxiety disorder compared to the non - religious group (Koenig et al, 1993). Other investigators have reported similar results (lower levels of anxiety among the more religious) in samples of both healthy and medically ill subjects (Thorson et al. 1990, Morris 1982, Kaczorowski 1989).

4) Depression:

Devout religious commitment (intrinsic religiosity in particular) is associated with lower rates of depression, and quicker recovery (Nelson 1989, Koenig 1995, O'Conner et al 1990).

Levin's research team (1996) also reported results from a study of 624 Mexican Americans from Texas who had been followed for over a decade. These investigators found that religiosity predicted lower depression and more positive attitude towards life 11 years later.

In 1980, Koenig and his colleagues conducted a study on 4,000 persons in central North Carolina to determine whether those who were more religiously active would be more or less depressed than those who were not

religious. Persons who were more involved in religious activities were only about one-half as likely to be depressed as those who were less religious. The finding was true regardless of age, sex, race, level of social support, and the degree of physical illness or functional disability. This study was presented at the *American Association for the Advancement of Science* annual meeting (Koenig et al. 1996).

The last study replicated the results obtained in an earlier one by the same author and his colleagues, when he studied 2,969 persons of all ages, and found a lower rate of depression among the more practicing religious persons (Koenig et al 1994 a).

Investigators in Massachusetts (Morse et al 1987), California (Nelson 1977), and other areas of the United States and Canada, have also reported similar findings (Koenig 1997).

Kennedy and colleagues in the department of Psychiatry at Albert Einstein College of Medicine (1996) studied 1,855 New York City residents, and reported an almost 40 percent increase in the risk of depression among the less religious.

5) Suicide:

A number of researchers have reported lower rates of suicide among those who are more religiously involved (Martin 1984, Stack 1983, Breault et al. 1982). Kok and Aw (1990) also confirmed low rates of suicide among Muslims in 12 countries.

Three studies in Malaysia confirmed lower suicide rates for Muslims, but higher for Hindus (Maniam 1988, Ong & Leng 1992, Habil et al. 1993). Also a study of 50 suicides among Indian immigrants in South Africa found Hindus over-represented and Muslims under-represented (Gangat et al.1987). Again the same observation was reported in a study of suicides among the Indian population in Fiji. Although Hindus outnumber Muslims by five to one in Fiji, among suicides they are over-represented: 14 to 1 among males and 8 to 1 among females (Haynes, 1984). High rates are also reported from Hindus in Trinidad and Tobago (Mahy, 1993). It seems that Hindu philosophy has a more tolerant attitude towards suicide, in contrast to the Koran and Islamic tradition, which are all strongly condemnatory (Hassan 1983).

6) Alcohol and Drug Misuse:

Almost every study that has ever examined the relationship between religion and alcohol and substance abuse has found lower rates of abuse among the religious population (Koenig et al. 1994b, Parfrey 1976, Larson and Wilson 1980, Khavari and Harmon 1982, Krause 1991, Alexanderand Duff 1991). Besides the existence of religious doctrines that discourage or altogether ban (as in Islam) alcohol and drug abuse, religious communities help prevent addictions and facilitate recovery through community support and individual commitment, and through the other mechanisms of religious coping which will be discussed later.

7) Religion and Self-esteem:

Self-esteem is another important mental health outcome because a lack of it has been strongly linked with depression. Krause and colleagues at the school of Public Health, University of Michigan, examined the relationship

between religious coping and self-esteem in a large sample and found that persons who relied heavily on religion to cope had very high levels of self-esteem. They concluded that feelings of self-worth tend to be lowest for those with very little religious commitment (Krause, 1995).

8) Treatment Studies:

An important evidence for religion's positive effects on mental health comes from studies that have successfully used religious interventions to treat emotional disorders. Propst and his colleagues (1992) compared the effectiveness of two types of cognitive-behaviour psychotherapy in the treatment of depressed patients. One version was a standard treatment protocol (secular CBT); the other version included religious content based on counselling practices used by Protestant and Catholic clergy (religious CBT).

In this study Religious CBT gave Christian rationales for restructuring thought processes, used religious arguments to counter irrational thoughts, and used religious imagery as part of the behaviour component. A sample of forty religious patients was randomly assigned to either group. Results showed that religious CBT group responded significantly much quicker than did the secular CBT group.

In a second study, Azhart and his colleagues (1994) assessed the effectiveness of religious intervention in the treatment of Muslim patients with anxiety disorder. Sixty-two patients were randomly assigned to treatment or control groups. Both groups received medication and supportive psychotherapy for anxiety. In addition, however, one group received a religious intervention similar to the religious CBT described in the previous study but on Islamic basis. After three months, the religious intervention group scored significantly lower on anxiety tests than did the group without religious treatment.

Also, in a previous study, it has been concluded that religious counselling appears to be more effective than standard approaches in working with religious clients (Propst 1980).

Other investigators (Al-Radi 1993, Johnson et al, 1994 and Pecheur and Edwards 1984) also have arrived at the same conclusions.

Discussion:

In a substantial number of studies, across diverse groups and dealing with diverse problems, religious coping emerges as an important predictor of adjustment. Religious coping adds a unique dimension to the coping process and complements the traditional psychological interventions when the therapist uses the patient's religious frame of reference as an aid in therapy. On the basis of this scientific evidence, the claims of Sigmund Freud and Albert Ellis against religion should be questioned. Their arguments were based largely on personal opinions (both are known to have been religious rejectionists), and their own anecdotal case reports. These clinical samples represent heavily biased selection of cases that support a person's worldview. (Koenig, 1997). The value of such evidence is very doubtful. Neurotic and pathological uses of religion do occur in individual cases, but are not widespread, nor characteristic of the vast majority of religious population. It is

also worth mentioning that Freud's theories have been persistently criticized for their scientific inadequacy (Atkinson et al. 1990, Gleitman, 995).

Adaptive religious coping seems to work through several natural mechanisms, among which are the following:

1) Spiritual aspects:

a) Spiritual Support:

According to religious concepts, the universe is not an accident. It is the work of a supremely powerful and intelligent being, Almighty God.

In this belief system, through prayer, anyone can at any time and in any place talk with all-powerful, all-knowing, all-merciful, God, who can respond to him/her. Empowered by God, virtually any situation can be viewed as manageable. There is no sin or mistake in life that cannot be forgiven.

Thus, no matter what person has done in the past he or she can start a fresh life again by the simple act of asking for forgiveness. Evidently, such beliefs may indeed bring emotional comfort and reassurance, not only in everyday life but also in the most difficult moments.

b) Submission to God's Will:

According to the same concepts, we have to accept whatever we face, including pain and suffering, since everything that happens in the world is part of God's plan. This belief provides a sense of control over one's destiny, and offers comfort and reassurance, as there is an ultimate meaning in all of our encounters.

2) Psychological aspects:

In addition to the various psychological functions of religion as an ego support, which have been mentioned earlier, the following issues might also be considered:

a) Balance:

Religious doctrines promote a healthy, balanced acceptance of self, others and the world. Self-fulfilment, happiness, and self-esteem are not found through struggling to achieve these things for the self, but rather through offering service to others because of love for God and desire to serve God. Good deeds, suffering and sacrifice in this life are best rewarded in the afterlife.

b) Positive attitude towards the future:

Religion promotes hope and optimism with their very positive implications on self-esteem, well-being, and mental health in general.

3) Social aspects:

Active participation in the religious community brings people into contact with others of similar age who have common interests, and with whom social relationships may form. Religious doctrines promote social interaction

by encouraging positive social attitudes and self-sacrifice. Interpersonal support can result in formation of new healthy social networks, which can facilitate positive personality changes (e.g. helping recovering alcoholic). Research has shown that persons who provide support to others have higher well-being than those who do not (Krause 1987, and Krause et al. 1992).

4) Preventive aspects:

Religion serves an important preventive role. Serious problems such as alcohol and drug abuse, parasuicide, AIDS, child abuse, sexual deviations and high-risk behaviours are prevented from developing in the first place.

In conclusion, religion clearly deserves greater recognition and attention from all mental health professionals. It represents resources that can help people cope better with emotional distress. Cox recommended that a 'religious history' - with any linked spiritual meaning - should be a routine component of the psychiatric assessment, and of preparing a culturally sensitive 'Care Plan'. He also urged that a religious counsellor should be included as a member of the multidisciplinary team (Cox 1996). Indeed, several spiritual strategies for counselling and psychotherapy have already been proposed (Richards & Bergin, 1997).

This fascinating area of rapidly growing research should invite mental health professionals to consider seriously, adopting the more comprehensive holistic **'bio-psycho-socio-spiritual'** model when dealing with mental health problems.

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M. O. Salem, MB ChB, DPM, MRCPsych,
Assistant Professor, and Consultant Psychiatrist, Adult General Psychiatry
Faculty of Medicine, UAE University
PO Box: 17666, Al-Ain
United Arab Emirates