JPPS 2007; 4(2): 78-82 REVIEW ARTICLE

RELIGION, FAITH AND PSYCHIATRY (A REVIEW)

Avinash De Sousa

This article aims to explore the relationships between religion and psychiatry, its implications for the treatment of mental disorders, and the use of religion, religious beliefs and spiritual texts in psychotherapy and clinical psychiatric practice. This article tries to bring out the importance and relevance of religion and spirituality in modern-day clinical practice.

**Keywords**: Religion, Faith, Psychiatry

# INTRODUCTION

Clinical experience suggests that considering religion and spirituality can be important in treatment. In an era of burgeoning neuroscience research emphasis, there seems to be an increased interest in religion and spirituality. There are attempts to see religion and spirituality from perspectives of developmental psychopathology as well as in the form of risks and protective factors for mental illness. The competent psychiatrist is a diagnostician, healer, physician and a therapist. Any factor such as religion and spirituality that may ameliorate or cause distress must be a part of the psychiatrist’s armamentarium. Today there is a growing amount of literature on the effects of religion and spirituality on mental illness, as well as on how to work with religious and spiritual issues in treatment. There is also an increasing epidemiological database of studies on religion and spirituality that has resulted in them coming under more careful scientific scrutiny1. One often asks if religion and spirituality are just components of culture? Religion and spirituality are at times subsumed under the broader aspects of culture but are never fully defined or predicted by it, more so in nations like India where the cultural landscape becomes more culturally and ethnically diverse. In fact it is wise to say that religion and spirituality actively shape and are shaped by the cultures from where they arise.

## Relevant Terminology

The domain of religion and spirituality introduces a number of terms to the clinician. This is often confusing and bewildering for the busy clinician. There remains considerable diversity in the various terms used but a general consensus has evolved over the last few de-

Correspondence :

**Dr. Avinash De Sousa,** Consultant Psychiatrist & Director, Get Well Clinic and Nursing Home, Mumbai, India

cades. The term *‘religion’* refers to an organized system of principles, beliefs, rituals, practices and related symbols that brings the individual closer to the sacred or ultimate truth or reality. The term *‘spirituality’* includes religion and relationships with others in a faith based community. It includes an individual’s search for understanding of life’s deepest mysteries and the most perplexing questions about what is sacred, transcendent or of ultimate importance2.

A third term used increasingly is *‘worldview’* which refers to an intellectual construction or belief system which is a philosophy of life that addresses life’s most basic questions of the origins, purpose, the meaning of suffering and death and what constitutes a good life3. This may be a part of a belief system of an organized religion or may stand on its own. Many other terms need to be mentioned at this point. The term *‘religious preference’* refers to an individual’s claim of belonging to a particular religious group. The term *‘Church affiliation’* refers to belonging to a church, temple, mosque or other house of worship and having one’s name on the roll or membership list. *‘Church involvement’* refers to attendance, participation in groups and committees and providing financial support but must not be mistaken for piousness, religious piety or sincerity of personal faith. *‘Religious beliefs’* refers to belief in God and the teachings found in the sacred religious texts. *‘Personal religious behavior’* is distinct from church or group religious behavior and includes individual prayer, meditation, study of religious texts and other behaviors that are required and seen as spiritually beneficial from the individual’s faith tradition4. These terms shall help the busy clinician identify with the patient and the family and their tradition irrespective of their specific faith. One point noteworthy is that the literature in the field now distinguishes appropriately and accurately between religion and spirituality. *‘Intrinsic religiosity’* is a term used to describe religious people that derive significance and life direction from their religious beliefs. *‘Extrinsic religosity’* is a term that describes the characteristics of people that appear to be interested in organized religious belief systems to achieve a non religious goal4.

## Religion and Health

Religious and spiritual outlooks often determine attitudes towards diet, exercise, sexuality, reproduction, education, parenting, death and dying, peer relationships, medical decision making and attitudes towards medications and the medical fraternity. Many researchers have stated that the strength and prevalence of religious beliefs must be considered in clinical decision making during both physical and mental health5. It is the outcome of various studies that physicians must consider the religious orientation of their patients while diagnosing and implementing treatment plans6-9. A survey conducted amongst patient revealed that 75% felt the need for physicians to address spiritual issues as a part of medical care while 40% felt that they want their physician to discuss their religious faith with them10. Earlier assessment of religious beliefs were considered unnecessary and inappropriate11-12 while religious commitment has also been seen as few as a cause of future psychiatric disorder to come13. Even psychiatrists in the past have felt that religious commitment was irrelevant and even pathological in the clinical setting14.

However, today there is a growing need to incorporate the study of religions and spirituality in medical schools at both an undergraduate and post graduate level15. A review over a ten year period of studies published in the Journal of Family Practice revealed that 81% had a positive association between religion and physical health, 15% were neutral while only 4% revealed a negative association16. These studies involve diverse study population with diverse clinical disorders, various ages, nationalities, both sexes and different experimental methods. An association between religion, faith and mental health assessed in two leading journals between 1978 and 1989 revealed that 84% showed a positive association between religion and mental health. Only 2.7% of these studies showed a harmful association17.

In most areas of research, findings are more likely to be published when they attain statistical significance and cohere with the expectations that the field has developed in those areas of research. A similar bias may examine the highly optimistic corpus of literature on religion, faith and mental health. Religion and faith have always been secondary in most medical studies that have addressed them. The findings on religion and mental health are often found buried in a table as an after thought in the discussion section of the article18. Several reviews suggest that psychiatry’s negative impact of religion and faith are not based on research but rather on a skewed view of clinical experiences or worse still, personal biases against religion and spirituality19.

Today clinicians must agree that patients may have different belief systems and faiths though all these sys-

tems share common goals and have points of common concern. Clinicians are advised to be *ecumenical* in their approach which refers to having a welcoming attitude towards a wide range of beliefs and practices20.

## Religion, Faith and Substance Abuse

Religious commitment may be related to lower levels of substance abuse. Numerous studies have linked drug abuse to a lack of purpose in life along with a lack of religiosity21-22. Religiously committed people are noted to consume lesser amounts of alcohol and drugs and are less likely to suffer from clinical and social consequences like ardent substance abusers23. Numerous studies have predicted that religion separates those who do not take to substance abuse24 and the same has been replicated in studies amongst adolescents25. Religious commitment is known to increase church attendance, influence and adherence to the norms of the religious groups and a reduction in the intake of alcohol and drugs. It also promotes friendship with peers that do not consume drugs and alcohol. It enhances physical and mental health that in turn reduces the risk of substance abuse. Parental influences through religious beliefs and faith have shown to influence substance use in adolescents26. Community studies have shown a positive relationship between personal religious beliefs and reduced substance use amongst adolescents and adults27. However religious outlook has had little to do with substance abuse among those arrested for excess alcohol28. Religious coping mechanisms are also known to improve management of life events and thus reduces the risk of moving towards substance abuse29.

## Religion, Faith, Depression and Suicide

On the whole, religious involvement seems to have an inverse relationship with depression and suicide. Religious beliefs appear to be associated with lower levels of hopelessness and with less depression30. A lack of spiritual support as denoted by low rates of church attendance has been associated with higher rates of depression31. Gender differences in the protective benefits of religiousness against depression have been consistently reported while the mechanisms for them are not clear. Researchers have shown that perhaps males report a more legalist view of God and hence derive less comfort and support from the relationship32. High levels of spiritual and religious belief have been correlated with low suicide rate in the community33. This is strongly linked to high levels of orthodox belief and religious devotion and not to church attendance. The protective benefits of religion in depression and suicide are linked not only to measures of personal religious devotion but is also linked to parental religiousness34. A review that analyzed sixteen studies on religion and suicide found that religious commitment was inversely related to the occurrence of suicide in 81% cases35. A nationwide increase in suicide rates with overall decline in church attendance rates has also been noted36-37.

## Religion, Faith and Sexuality

People who are more religious, have often a negative attitude towards premature sexuality and in turn delay sexual behavior. Adolescents involved in religious life are 50% less likely to engage in sexual intercourse than their non religious peers32. The religious involvement of the family has been found to play an important role in delaying sexual intercourse38. One study has however found that church going women were less likely to use contraceptive methods resulting in a greater risk of unsafe sexual behavior and unwanted pregnancies39. Religious orientation of parents influences the ideals about marriage, family size, power, intimacy, gender roles as well as methods of rearing and disciplining children40-41.

## Religion, Faith and Schizophrenia

Religious practices are common amongst schizophrenic patients all over the world42-45. Homicides have been perpetrated by religiously deluded patients. The plucking of the eyes and other body parts are known in cases of schizophrenia that have taken statements from the Bible literally. There has also been studies that have described the relation between anti Christ delusions and violence in schizophrenia46-49. Religious practices in schizophrenic patients have been associated with a higher rate of developing religious delusion though not always necessary50-51. Many patients with schizophrenia take medications, visit psychiatrists and yet perform rituals and undergo exorcisms while they visit faith healers52. Religious commitment reduces the co-morbidity of substance use along with the occurrence of suicide in schizophrenia53-54.

In a study of inpatients with schizophrenia, people with religious delusions were also more severely ill, had more hallucinations and were ill for longer periods of time50. All over the world the prevalence of religious delusions amongst schizophrenics varies. There is a rate of 21% reported in Germany compared to 7% in Japan55, 21% in Austria against 6% in Pakistan56 and 36% in USA57. Compared to the secular methods of coping, religion and spirituality can offer an answer to the problems of human insufficiency. Thus it is not surprising that patients with schizophrenia use religion to cope. The studies on religion and schizophrenia bear essentially on the acute phase of the illness while only a few studies examine patients in remitted states when this aspect can be ascertained58. Based on the role theory and depth psychology, religion provides patients with identification models which with the active support of the religious community, can facilitate recovery59.

The relationship between religion and schizophrenia ranges from the worst to the best. In each patient often we may be able to point out a specific pattern of the relationship between religion and the existent psychosis. Considering religion and spirituality in the treatment of those suffering from schizophrenia may help to reduce pathology, enhance coping and foster recovery.

## The Neurobiology of Religion

Religious experiences are brain based like any other human experience. With the development of advances in neurosciences, scientists are now able to explore the neural correlates of religion and spirituality. Among some of the important results studies have shown that the temporolimbic system is the substrate for religious-numinous experience60. The right temporal lobe is seen to be activated in mystical states61 versus the left temporal lobes that is activated in religious delusions62. The biological basis of spirituality lies in the serotonergic system63. There is also a specific ‘God Spot’ in the brain that is activated in spirituality studies64.

## Conclusions and Implications

In this review I have tried to be consistent with scientific facts and yet hope that it shall be able to help the clinician who treats problems influenced by the patient’s and family’s religious faith and spiritual position. I have tried to be as descriptive and neutral as possible in the spirit of scientific discourse. It is implicit that in issues such as religion, faith and psychiatry, all individuals including clinicians have their own personal views no matter how they express it. I have limited discussions to general issues and specific faiths that are commonly encountered in routine clinical practice. Exclusion of any specific faith in the discussion has been dictated solely by space constraints. I hope that this article serves as a springboard for future reflection, dialogue and scientific study in India of the role of religion and spirituality in modern day psychiatry and clinical practice. If it does then probably I have achieved my goal.

# REFERENCES

1. Josephson AM, Dell ML. Religion and spirituality in child and adolescent psychiatry: a new frontier. Child Psych Clin North Amer 2004; 13: 1-15.
2. Koenig HG, McCullough ME, Larson DB. Handbook of Religion and Health. New York : Oxford University Press; 2001.
3. Freud S. The question of a weltanschauung. In: Strachey J, translator & editor. The Standard Edition of the complete psychological works of Sigmund Freud, vol 22. London: Hogarth Press; 1962: 158-67.
4. Hoge DE. Religion in America. In : Shafranske EP, editor. Religion and the clinical practice of psychology. Washington DC : American Psychological Association; 1996: 21-42.
5. Larson DB, Larson SS. The Forgotten Factor in Physical and Mental Health: What Does Research Show. Rockville Md : National Institute for Healthcare Research; 1994.
6. Andreasen NJ. The role of religion in depression. J Religion Health 1972 ; 11 : 153-66.
7. Chu C, Klein HE. Psychological and environmental variables in the outcomes of black schizophrenics. J Natl Med Assoc 1985; 77: 793-6.
8. Frank JD. Persuasion and Healing: A comparative study of Psychotherapy. Baltimore Md: John Hopkins University Press; 1973.
9. Lukoff D, Lu F, Turner R. Towards a more culturally sensitive DSM-IV: psychoreligious and psychospiritual problems. J Nerv Ment Dis 1992; 180: 673-82.
10. King DE, Bushwhick B. Beliefs and attitudes of hospital patients about faith, healing and prayer. J Fam Pract 1994; 39: 349-52.
11. McKee D, Chappel N. Spirituality and medical practice. J Fam Pract 1992; 35: 201-8.
12. Deikman A. Comments on the GAP report on mysticism. J Nerv Ment Dis 1977; 165: 213-17.
13. Watters W. Deadly Doctrine : Health, Illness and Christian God talk. Buffalo NY: Prometheus Books ; 1992.
14. Kuhn CC. A Spiritual inventory for the medically ill patient. Psychiatr Med 1988; 6: 87-100.
15. Barnard D, Dayringer R, Cassel CK. Towards a person-centred medicine : religious studies in the medical curriculum. Acad Med 1995; 70: 806-13.
16. Craggie FC, Larson DB, Liu Y. References to religion in the Journal of Family Practice : dimensions and valence of spirituality. J Fam Pract 1990; 30: 477-80.
17. Larson DB, Sherrill KA, Lyons JS, Cragie FC Jr, Thielman SB, Greenworld MA, et al. Association between religious commitment and mental health reported in the American Journal of Psychiatry and the Archives of General Psychiatry. 1978-1989. Am J Psychiatry 1992; 149: 557-9.
18. Cooper HM. The Integrative Research Review. Beverly Hill Calif : Sage Publications; 1994.
19. Koenig HG, editor. Handbook of Religion and Mental Health. San Diego (CA): Academic Press; 1998.
20. Mead FS, Hill SS. Handbook of denominations in the United States. 11th ed. Nashville TN: Abingdon Press; 2001.
21. Heather N, Miller WR, Greeley J, editor. Self Control and the Addictive Behavior. Sydney, Australia: McMillan Publishing; 1991: 262-79.
22. Larson DB, Wilson WP. The religious life of alcoholics. South Med J 1980; 73: 723-7.
23. Mood RD, Mead L, Pearson T. Youthful precursors of alcohol abuse in physicians. Am J Med 1990 ; 88 : 332-6.
24. Gorusch RL, Butler MC. Initial drug use : a view of predisposing social psychological factors. Psychol Bull 1976; 3 : 120-37.
25. Hays RD, Stacy AW, Widaman DMR, Arnold S, Prince LM. Multistage path models of adolescent alcohol and drug use: a reanalysis. J Drug Issues 1985; 16: 357-69.
26. Merrill RM, Salazar DR, Gardner NW. Relationship between family religiosity and drug use behavior amongst youth. Soc Beh Personality 2001; 29: 347-58.
27. Wills TA, Yaeger AM, Sandy JM. Buffering effect of religiosity for substance abuse. Psychol Addict Behav 2003; 17: 24-31.
28. Bahr SJ, Hawk RD, Wang G. Family and religious influences on adolescent substance abuse. Youth Soc 1993; 24: 443-65.
29. D’Onofrio BM, Murrelle L, Eaves LJ, McCullough ME, Landis JL, Maes HH. Adolescent religiousness and its influence on substance use : preliminary findings from the Mid Atlantic School Age Twin Study. Twin Res 1999; 2: 156-68.
30. Murphy PE, Ciarrocchi JW, Piedmont RL, Cheston S, Peyrot M, Fitchett G. The relation of religious beliefs and practices, depression and hopelessness in persons with clinical depression. J Consult Clin Psychol 2000; 68: 1102-6.
31. Wright LS, Frost CJ, Wisecarver SJ. Church attendance, meaningfulness of religion and depression symptomatology among adolescents. J Youth Adolesc 1993; 22: 559-68.
32. Spika B, Hood RW, Gorusch RL. The Psychology of Religion. Englewood (NJ): Prentice Hall; 1985.
33. Neeleman J, Wessely S, Lewis G. Suicide acceptability in African and white Americans. J Nerv Ment Dis 1998; 186: 12-6.
34. Mahoney A, Pargament KI, Tarakeshwar N, Swank AB. Religion in the home in the 1980s and the 1990s : meta analytic review and conceptual analysis of the links between religion, marriage and parenting. J Fam Psychol 2001; 15: 559-96.
35. Gartner J, Larson DB, Allen G. Religious commitment and mental health : an empirical review of literature. J Psychol Theol 1991; 19: 6-25.
36. Stack S. The effect of decline of institutionalized religion on suicide : 1954-1978. J Sci Study Religion 1983; 22: 239-52.
37. Martin WT. Religiosity and United States suicide rates 1972-1978. J Clin Psychol 1984; 40: 1166-9.
38. Murstein BI, Mercy T. Sex, drugs, relationships, contraception and the fear of disease on the college campus over 17 years. Adolescence 1994; 29: 303-22.
39. Studer M, Thornton A. Adolescent religiosity and contraceptive usage. J Marriage Fam 1987; 49: 117-28.
40. Danso H, Hunsberger B, Pratt M. The role of parental religious fundamentalism and right wing authoritarianism in child rearing goals and practices. J Sci Study Religion 1997; 36: 496-511.
41. Strayhorn JM, Weidman CS, Larson D. A measure of religiousness and its relation to parent and child mental health variables. J Community Psychol 1990; 18: 34-43.
42. Kirov G, Kemp R, Kirov K, David AS. Religious faith after psychotic illness. Psychopathology 1998; 31: 234-45.
43. Kroll J, Sheehan W. Religious beliefs and practices amongst inpatients at Minnesota. Am J Psychiatry 1989; 146: 67-76.
44. Brewerton TD. Hyperreligiosity in psychotic disorders. J Nerv Ment Dis 1994; 182: 302-4.
45. Neeleman J, Lewis G. Religious identity and comfort beliefs in three groups of psychiatric patients and a group of medical controls. Int J Soc Psychiatry 1994; 40: 124-34.
46. Kraya N, Patrick C. Folie a deux in the forensic setting. Aus NZ J Psychiatry 1997; 31: 883-8.
47. Field H, Waldfogel S. Severe ocular self injury. Gen Hosp Psychiatry 1995; 17: 224-7.
48. Waugh A. Auto castration and biblical delusions in schizophrenia. Br J Psychiatry 1986; 149: 656-9.
49. Silva JA, Leong GB, Weinstock R. Violent behaviors associated with anti Christ delusions. J Forensic Sci 1997; 42: 1058-61.
50. Siddle R, Haddock G, Tarrier N, Faragher EB. Religious delusions in patients admitted to the hospital with schizophrenia. Soc Psychiatry Psychiatr Epidemiol 2002; 37: 130-8.
51. Getz DE, Fleck DE, Strakowski SM. Frequency and severity of religious delusions in Christian patients with psychosis. Psychiatry Res 2001; 103: 87-91.
52. Pfiefer S. Demonic attributions in non delusional disorders. Psychopathology 1999; 32: 252-9.
53. Kendler KS, Liu XO, Gardner CO, McCullough ME, Larson D, Prescott CA. Dimensions of religiosity and their relationship to the lifetime occurrence of schizophrenia and substance use disorders. Am J Psychiatry 2003; 160: 496-503.
54. Koenig HG, Larson DB, Larson SS. Religion and coping in serious medical illness. Ann Pharmacother 2001; 35: 352-9.
55. Tateyama M, Asai M, Kamisada M, Hashimoto M, Bartels M, Heimann H. Comparison of schizophrenic delusions between Germany and Japan. Psychopathology 1993; 26: 151-8.
56. Stompe T, Friedman A, Ortwein G, Strobl R, Chaudhry HR, Najam N, et al. Comparison of schizophrenic delusions between Austria and Pakistan. Psychopathology 1999; 32: 225-34.
57. Appelbaum PS, Robbins PC, Roth LH. Dimensional approach to delusions : comparison across types and diagnoses. Am J Psychiatry 1999; 156: 1938-43.
58. Murphy M. Coping with the spiritual meaning of psychosis. Psychiatr Rehabil J 2000; 24: 179-83.
59. Fallor RD. Spiritual and religious dimensions of mental illness recovery narratives. New Dir Ment Health Serv 1998; 35-44.
60. Pietrini P. Towards a biochemistry of the mind ? Am J psychiatry 2003; 160: 1907-8.
61. Saver JL, Rabin J. The neural substrates of religious experience. J Neuropsychiatry Clin Neurosci 1997; 9: 498-510.
62. Puri BK, Lekh SK, Nijran KS, Bagary MS, Richardson AJ. SPECT neuroimaging in schizophrenia with religious delusions. Int J Psychophysiol 2001; 40: 145-8.
63. Borg J, Andree B, Soderstrom H, Farde L. The serotonin system and spiritual experiences. Am J Psychiatry 2003; 160: 1965-9.
64. Zohar D, Marshall I. Spiritual intelligence: the ultimate intelligence. New York: Bloomsburg Publishing, 2000.