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RELIGION, FAITH AND PSYCHIATRY (A REVIEW)

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# ABSTRACT

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

**Key words**: Religion, Faith, Psychiatry.

# INTRODUCTION

Clinical experience suggests that considering re- ligion 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 spiri- tuality from perspectives of developmental psychopa- thology 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 amelio- rate 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 in- creasing epidemiological database of studies on reli- gion 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 de- fined 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 reli- gion 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 confus- ing 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-

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cades. The term *‘religion’* refers to an organized system of principles, beliefs, rituals, practices and related sym- bols 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 under- standing of life’s deepest mysteries and the most per- plexing 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 prefer- ence’* 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 atten- dance, participation in groups and committees and pro- viding 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 teach- ings found in the sacred religious texts. *‘Personal reli- gious behavior’* is distinct from church or group religious behavior and includes individual prayer, meditation, study of religious texts and other behaviors that are re- quired 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 re- ligion and spirituality. *‘Intrinsic religiosity’* is a term used to describe religious people that derive significance and life direction from their religious beliefs. *‘Extrinsic religi-*

*osity’* 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 relation- ships, medical decision making and attitudes towards medications and the medical fraternity. Many research- ers have stated that the strength and prevalence of reli- gious beliefs must be considered in clinical decision making during both physical and mental health5. It is the outcome of various studies that physicians must con- sider the religious orientation of their patients while di- agnosing and implementing treatment plans6-9. A sur- vey 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 com- mitment 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 incor- porate 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 pub- lished in the Journal of Family Practice revealed that 81% had a positive association between religion and physical health, 15% were neutral while only 4% re- vealed a negative association16. These studies involve diverse study population with diverse clinical disorders, various ages, nationalities, both sexes and different ex- perimental methods. An association between religion, faith and mental health assessed in two leading jour- nals 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 de- veloped in those areas of research. A similar bias may examine the highly optimistic corpus of literature on re- ligion, 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 im- pact 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 atti- tude towards a wide range of beliefs and practices20.

## Religion, Faith and Substance Abuse

Religious commitment may be related to lower lev- els 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 conse- quences 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 con- sume drugs and alcohol. It enhances physical and men- tal 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 sub- stance use amongst adolescents and adults27. However religious outlook has had little to do with substance abuse among those arrested for excess alcohol28. Reli- gious 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 ben- efits of religiousness against depression have been con- sistently 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 in- crease 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 nega- tive 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 un- safe sexual behavior and unwanted pregnancies39. Re- ligious 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 schizo- phrenic 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 schizophre- nia take medications, visit psychiatrists and yet perform rituals and undergo exorcisms while they visit faith heal- ers52. 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 de- lusions 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, re- ligion and spirituality can offer an answer to the prob- lems 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 stud- ies examine patients in remitted states when this aspect can be ascertained58. Based on the role theory and depth psychology, religion provides patients with identifica- tion models which with the active support of the reli- gious community, can facilitate recovery59.

The relationship between religion and schizophre- nia 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 psy- chosis. Considering religion and spirituality in the treat- ment 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 ad- vances in neurosciences, scientists are now able to ex- plore the neural correlates of religion and spirituality. Among some of the important results studies have shown that the temporolimbic system is the substrate for reli- gious-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 serotoner- gic 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 posi- tion. 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 dis- cussions to general issues and specific faiths that are commonly encountered in routine clinical practice. Ex- clusion of any specific faith in the discussion has been dictated solely by space constraints. I hope that this ar- ticle serves as a springboard for future reflection, dia- logue 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.

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