Understanding and addressing religion among people with mental illness

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This article reviews recent advances in the domain of psychiatry and religion that highlight the double-edged capacity of religion to enhance or damage health and well-being, particularly among psychiatric patients. A large body of research challenges stereotyped views of religion as merely a defense or passive way of coping, and indicates that many people look to religion as a vital resource which serves a variety of adaptive functions, such as self-regulation, attachment, emotional comfort, meaning, and spirituality. There is, however, a darker side to religious life. Researchers and theorists have identified and begun to study problematic aspects of religiousness, including religiously-based violence and religious struggles within oneself, with others, and with the divine. Religious problems can be understood as a by-product of psychiatric illness (secondary), a source of psychiatric illness (primary), or both (complex). This growing body of knowledge underscores the need to attend more fully to the potentially constructive and destructive roles of religion in psychiatric diagnosis, assessment, and treatment. In fact, initial evaluative studies of the impact of spiritually integrated treatments among a range of psychiatric populations have shown promising results. The article concludes with a set of recommendations to advance future research and practice, including the need for additional psychiatric studies of people from diverse cultures and religious traditions.

Key words: Religion, spirituality, religious resources, religious coping, religious struggles, religiously-based violence, religious assessment, spiritually integrated treatment

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The last 20 years have witnessed a sharp rise of scientific interest in the links between religion and psychological functioning (1). In contrast to commonly held stereotypes about religion and mental health, a significant body of theory and research indicates that religion is a source of strength and resilience for many people, including those with serious psychiatric disorders (2). It remains true, however, that religion can be problematic for some patients.

This article begins by placing the current status of the field in historical context, noting the history of troubled relations that has marked psychiatry and religion. We then review recent advances in the domain of psychiatry and religion that highlight the double-edged capacity of religion to enhance or damage health and well-being, particularly among psychiatric patients. This article concludes by considering the implications of this literature for psychiatric assessment and treatment.

A TROUBLED HISTORY BETWEEN PSYCHIATRY AND RELIGION

There is a long history of suspicion and, at times, antagonism between psychiatry and religion. Freud famously stated that religion represents a "defense against childish helplessness" and went on to conclude that "surely [such] infantilism is destined to be surmounted" (3). Negative religious attitudes of this kind within psychiatry and other mental health disciplines were commonplace for much of the 20th century. Religion was often stereotyped as defensive or regressive in character, fostering a passive retreat from problems, the outright denial of pain and suffering, or florid symptomatology. For example, DSM-III contained a disproportionate number of examples of religious expressions of major psychopathology, such as religious hallucinations and delusions (4). Oftentimes, religious issues were simply ignored, as illustrated by infrequent references to religion within major psychiatric texts and journals (5). Some religious groups reciprocated with negative attitudes of their own toward psychiatry and discouraged or prohibited adherents from seeking out psychiatric treatment (6).

The tensions between psychiatry and religion are rooted in a number of factors. These include: perceptions that the world views grounded in science and faith are fundamentally irreconcilable (7); considerably lower levels of religiousness among psychiatrists than in the general population (8), leading psychiatrists to underestimate the salience of religion to patients; and a lack of psychiatric education and training to help practitioners understand and address patients' religious resources and problems (9).

This picture has begun to change in recent years, reflecting the growth of theory and research on religion, psychological functioning, and psychiatric disorders as well as a recognition of the need for a culturally sensitive approach

to psychiatric care. The field is now moving to a more nuanced understanding of religion, one which is cognizant of its double-sided capacity to support and strengthen people grappling with serious mental illness or exacerbate their pain and suffering.

RELIGION AS RESOURCE

Empirical studies show that religion is one of the first resources people and their loved ones turn to when faced with serious illness (2). For example, according to one study of outpatients with serious mental illness in Los Angeles, more than 80% reported that they used religion to cope with their illness and 65% indicated that religion helped reduce the severity of their symptoms (10). Similar findings have been reported in other countries. In a study comparing European patients with psychosis to a nonpsychiatric control group, the psychiatric patients reported a larger number of religious beliefs and practices that offered comfort during times of stress (11). In another study of Hindu family caregivers of patients with schizophrenia in a public hospital in India, 90% reportedly coped by praying to God, and 50% reported that religion was a source of solace, strength, and guidance (12).

Several empirical studies also challenge overly simplistic views of religion as a passive way of coping or a source of denial (2). For example, higher levels of religiousness have been associated with greater feelings of empowerment and self-efficacy among patients with serious mental illness (13), and more active attempts to resolve problems among women with ovarian cancer (14). In contrast to the view that religiousness promotes avoidance and denial, studies have linked greater religious involvement among women to a shorter length of time to schedule a visit with a physician after noticing symptoms of breast cancer (15) and less reliance on thought suppression and denial as ways of coping among HIV-seropositive African American women (16). One interesting study found that, while higher levels of religiousness were unrelated to reports of the *presence* of pain among cancer patients, religiousness was related to reports of lower *levels* of pain (17). These findings suggest that religion may be involved in the reinterpretation rather than denial of pain.

Theory and research have also shown that religion serves a variety of adaptive functions for people, including those with serious mental illness. A content analysis of semistructured interviews with Swiss patients with serious mental illness revealed several functions of religion: meaning, comfort, self-respect, self-confidence, compassion, hope, love, and acceptance (18). Although theorists have debated about the most central purposes of religion, part of the power of this phenomenon may lie in its ability to meet a diverse array of human needs.

Self-regulation

Building on Freud's view that religion helps control undesirable sexual and aggressive urges, more recent theorists have emphasized the evolutionary advantages of religiously-based mechanisms that foster regulation of human impulses and desires (19). Consistent with this theory, a number of empirical studies have shown robust ties between religiousness and greater behavioral restraint with respect to substance use, crime and delinquency, suicidality, and sexual promiscuity.

People with serious mental illness may find the self-regulation afforded by religion particularly valuable. In one study of Swiss patients with schizophrenia or schizoaffective disorder, greater use of religious coping was predictive of fewer negative symptoms and better social functioning and quality of life 3 years later (20).

Attachment and connectedness

Sociologist E. Durkheim maintained that religion is most importantly about providing people with connectedness and identity: "The idea of society", he said, "is the soul of religion" (21). His thesis has been supported by several studies documenting that individuals who are more involved in public religious expressions (e.g., worship attendance) report a larger network of social relationships and greater social support (22). However, it is important to note that individuals with serious mental illness often feel alienated from their religious institutions or other people more generally as a result of stigmatization or a history of insecure attachments (23). Religion may offer some compensation to these individuals through more secure attachments to sacred beings (e.g., God, Jesus, higher powers) who are perceived as more available and more accessible than their mortal counterparts (24).

Several studies have linked individual's perceptions of a secure relationship with God to lower levels of psychological distress. Relevant here too are the frequent reports of continued attachment to a loved one who has died. In one study of bereaved parents of pediatric cancer patients, 88% reported a continued connection with their deceased child (25). One grieving mother said: "I talk to him all the time. I 'keep him up on' what's going on at home and with all of us. I feel the strongest connection at the cemetery. I imagine his spirit in the trees behind his grave. When I begin to talk to him the wind almost always rustles the leaves, which tells me he's there" (25).

Emotional comfort

Freud and other theorists have maintained that religion functions in large part to allay the individuals' anxieties in a world of powerful forces that point to human frailty and finitude. Many studies have supported this theoretical perspective (22). For example, higher levels of religiousness have been associated with lower levels of depression especially among people facing more severe life stressors (26), less complicated grief among family caregivers of patients with dementia (27), and less anxiety and perceived stress among patients with panic disorder (28).

Beliefs in an afterlife appear to play a particularly key role in reducing basic

existential anxieties. Experimental studies in the domain of terror management theory have revealed that reminders of personal mortality increase beliefs in an afterlife, and beliefs in an afterlife reduce the anxieties associated with dying (29).

Meaning

Based on his extensive anthropological field studies, C. Geertz concluded that the most critical function of religion is meaning making (30). He wrote: "the effort is not to deny the undeniable – that there are unexplained events, that life hurts, or that rain falls upon the just – but to deny that there are inexplicable events, that life is unendurable, and that justice is a mirage". When 2000 people were surveyed about why they were religious, the most common response was "religion gives meaning in life" (31).

One study of hospice care providers identified several forms of benevolent religious reframing that lent meaning to the experience, such as appraisals that caregiving offers an opportunity to grow spiritually or represents a part of God's plan or will (32). These appraisals were associated with more positive outcomes and purpose in life. In a longitudinal study of parents who had suffered the violent death of a child, those who made more use of religious resources were able to find more meaning in the loss of their child 5 years later (33). Working with Flemish patients with chronic pain, another group of researchers reported that praying was associated with greater pain tolerance, not pain severity; the relationship between prayer and tolerance was mediated by positive reappraisals of the pain (34).

Spirituality

To the religiously minded, the most important purpose of religion is spirituality itself. The world's religious traditions insist that the search for the sacred takes priority over more temporal matters, though these faiths also offer a way to reconcile the spiritual with the human. Psychologist and theologian P. Johnson captured this sentiment: "it is the ultimate Thou whom the religious person seeks most of all" (35). From this perspective, people grappling with serious illness are motivated to sustain themselves spiritually as well as psychologically, socially, and physically (36). Empirical studies have shown that people are generally quite successful in maintaining their faith in difficult times. For example, in one investigation of individuals who had experienced multiple traumas, 73% reported no religious change after the second event (37).

RELIGION AS PROBLEM

A number of theorists have attempted to move beyond global, stereotyped views of religion to delineate more specific aspects of religion that may be responsible for its troubling links with personal and social pathology. For example, Allport (38) articulated several characteristics of an "immature religious sentiment": simplistic and undifferentiated; fanatical and impulsive; lacking influence over conduct and values; intolerant and incomplete; and internally conflicted and fragmented. Pruyser (39) said that the "seamy side" of faith is marked by a sacrifice of the intellect, regressive fantasies, an inability to tolerate freedom, and neurotic coping styles. According to Pargament (40), an unhealthy spirituality is "dis-integrated"; it is ill-equipped to deal with the full range of internal and external life demands because it lacks comprehensiveness, depth, flexibility, dynamism, balance, and coherence.

Two aspects of problematic religiousness have received particular attention in recent years: religious struggles and religiously-based violence.

Religious struggles

Although people with serious mental illness are more likely to report that religion is a resource than a source of problems, a significant minority indicate that their faith contributes to their sense of anger, guilt, suffering, and despair (26). In recognition that religion can be distressing, DSM-IV-TR included under "other conditions that may be a focus of clinical attention" the category of religious and spiritual problems, such as loss or questioning of faith, spiritual emergency, and new religious movements (41).

Several researchers have begun to examine a related concept, religious struggles, defined as questions, tensions, and conflicts about spiritual issues within oneself (intrapsychic), with others (interpersonal), and with higher powers or God (divine) (42). For example, one young woman described divine struggles related to her bipolar illness: "I'm suffering, really suffering. My illness is tearing me down, and I'm angry at God for not rescuing me, I mean really setting me free from my mental bondage. I have been dealing with these issues for ten years now and I am only 24 years old. I don't understand why he keeps lifting me up, just to let me come crashing down again".

It is important to distinguish between religious struggles that are the end-result of psychopathology and those that lead to psychopathology (43). Secondary religious struggles are elicited by major traumas, including the diagnosis of a serious mental illness, which can shake or shatter an individual's most fundamental values and worldview. In this vein, according to one national survey of people in the United States, a wide variety of forms of psychopathology were associated with higher levels of religious struggles (44). Primary religious struggles trigger subsequent psychological problems. Several longitudinal studies have tied religious struggles to declines in mental health, physical health, and even greater risk of dying (45). Finally, in complex religious struggles, the problematic form of religiousness is both a cause and a consequence of psychopathology.

Religion-based violence

In spite of its capacity to foster compassion, humanness, and understanding, throughout the ages religion has at times been a source of abuse, persecution, terrorism, and genocide. These problems

continue today across the world, as illustrated by religiously-based terrorism, clergy sexual abuse, and religiously-supported genocide. To take one among unfortunately many examples, in 2001, a Belgian court convicted two Benedictine nuns, Sisters G. Mukangango and J. Kisito, of participating in the massacre of more than 7600 Tutsis at the Sovu convent in Butare (46).

No single explanation is likely to offer a complete understanding of a process as complex as religious violence. Theorists, however, have suggested several psychological and social causal factors: a) felt experiences of shame and humiliation that may be evoked by present or historic events; b) a splitting of the world into all-good and evil-demonic camps, based on an inability to tolerate ambivalence and ambiguity; c) submission to an overly idealized, yet humiliating institution based on a fear of abandonment; d) threats to ideals, ideologies, or institutions that evoke narcissistic rage; e) an insistence on total perfection and purification; f) doctrinal linkages between violence and purification; and g) sexual repression (47). Particular attention has been paid by some theorists to the critical role of religious leaders in fomenting violence. For example, Olsson (48) maintains that destructive cult leaders manifest a malignant form of narcissistic personality disorder in which, by virtue of their ability to manipulate and inflict pain and suffering on others, they are able to assuage their own history of rejection and abandonment and support their inflated sense of themselves.

Empirical research in this critically important area is in short supply. However, some studies have provided support for these theoretical perspectives. For example, in one set of experimental studies, exposure to divinely sanctioned violence in the scriptures was tied to increases in aggressiveness, especially for more religious individuals. The authors (49) concluded that "to the extent religious extremists engage in prolonged, selective reading of the scriptures, focusing on violent retribution toward unbelievers instead of the overall message of acceptance and understanding, one might expect to see increased brutality". Other studies have found that people who demonstrate an extrinsic religious orientation, one in which religion is used as a tool to serve nonreligious as opposed to spiritual ends, are more likely to demonstrate prejudice (50). These findings might also well apply to the problem of clergy sexual abuse, in which ministers hide behind the cloak of religion to gain access to vulnerable populations for their own destructive purposes. Still other research has suggested that people who believe that their sacred values are under attack are more willing to engage in aggressive, extremist responses (51).

IMPLICATIONS FOR PSYCHIATRIC PRACTICE

In recent years, theory and research within psychiatry and related mental health fields have challenged negative stereotypes about religion and led to a more nuanced view that recognizes the double-sided capacity of religion to foster both problems and solutions, distress and relief, among people with serious mental illness. Signs of the Janus-like character of religion can even be found within the same individual. In one study of patients dealing with religious delusions (52), many individuals reported that their faith was both a help and a hindrance, as illustrated in the following quote by a patient experiencing a malevolent spiritual aura: "The auras say 'we will catch him' and 'we will kill him', and they make me feel external pain. I spoke to the priest about the auras, and he helped me to find the courage to fight. God loves me and comforts me. With the help of God, I am winning against the auras".

A more differentiated view of religion holds significant implications for assessment and treatment.

Diagnosis and assessment

Recent advances in this area of study point to the need to attend more fully to the religious dimension in the process of assessment (40). Religion should be routinely included in the list of potential resources patients may draw on in dealing with their illness and other life stressors. Patients should be asked whether they have religious resources they can access to help them cope with their problems, just as they are asked about other resources, such as their family and social network, hobbies, and exercise. Conversely, it is important to examine whether religion is problematic for the patient. A simple question, such as "Have your problems affected your religiousness or spirituality?", can open the door to an exploration of religious struggles or other religious problems.

In the process of assessing religious problems, it is important to consider whether the problems are secondary to the psychiatric symptomatology, primary sources of psychiatric distress, or complex. This basic distinction will have significant implications for subsequent treatment. In many cases, problems in the spiritual realm such as religious hallucinations and delusions can be best understood as secondary to a primary psychiatric illness; religion in these instances may simply be the idiom or language through which the illness is expressed (53). Treatment of the psychiatric illness among people with secondary religious problems may result in spiritual as well as emotional improvement. However, in other cases in which religion is in itself a primary source of distress, a focus on the psychiatric illness may not be sufficient to produce significant change. Spiritually integrated treatments that address the religious dimension of the problem may be needed to facilitate progress.

It is important to add that a spiritually sensitive approach to diagnosis and assessment calls for a full appreciation of the patient's cultural context. Whether a religious belief is delusional and problematic generally cannot be determined on the basis of the content of the belief (54). As Miller and Kelley noted (55), "in some African communities, a person would be considered insane *not* to believe that the spirits of the dead actively influence an individual's life". In some cases, it is appropriate and necessary to consult with

members of a patient's religious subculture to determine whether a set of religious beliefs are normative within that particular context. More generally, psychiatric diagnosis and assessment must incorporate an understanding of the beliefs, practices, and values that define the patient's world.

Treatment

Religion speaks to highly sensitive issues that lie at the core of the individual's identity, commitments, values, and worldview. This holds true for people with serious mental illness. Patients are unlikely to engage in a conversation about the deepest side of themselves unless their psychiatrist demonstrates an openness to, interest in, and appreciation of the patient's religiousness. Case studies have illustrated how practitioners can provide this kind of sensitive, spiritually affirming care to patients without commenting on the ontological reality of the patient's experience, something that lies beyond the knowledge or authority of mental health professionals (56). In this sense, psychiatrists can approach the patient's religiousness in the same fashion as other dimensions of life. Speaking to this point from a psychodynamic perspective, Rizzuto (57) stated: "The analyst owes the patient a full analytic experience in which his [or her] private religious world is explored with the same attentiveness and respectful exploration as the rest of his [or her] psychic life". Several practitioners have reported that patients welcome this type of spiritually sensitive and integrative approach to treatment (58,59).

One of the most important questions is whether a spiritually integrated approach to treatment is, in fact, as effective or even more effective than traditional methods of care. Several studies have been conducted on this question, and the initial results are promising. One set of studies has examined the effectiveness of treatments that encourage the patient to draw more fully on his/her religious resources. Spiritually integrated treatments have shown better results than various comparative treatments in a number of groups, including: Muslim patients from Malaysia diagnosed with generalized anxiety disorder, dysthymic disorder, and major depression (60); depressed patients and patients with schizophrenia in Australia (61); women from the Church of the Latter Day Saints diagnosed with eating disorders in an inpatient setting (62); Jews dealing with subclinical worry and anxiety (63); and treatment-resistant opioid-dependent patients in the United States (64). Encouraging findings have also been reported in a few evaluative studies on the effects of spiritually integrated treatments that address religious problems among patient populations in the United States, including military veterans dealing with post-traumatic stress disorder symptoms (65) and women who have been sexually abused (66).

PROMISING DIRECTIONS

In spite of the knowledge that has been gained on the relationship between religion and serious mental illness, questions continue to outnumber answers. There are several promising areas for further work in this domain (67). First, most of the research and practice in this area has focused on Western cultures. The findings from this particular context have to be extended to other religious groups, countries, and cultures. Second, further studies are needed which can help psychiatrists identify and distinguish between religious resources and religious problems across religious groups and cultures as well as psychiatric diagnoses. Third, longitudinal research is called for that helps disentangle the complex interplay between religion and psychopathology; specifically, the ways mental illness may elicit secondary religious problems and/or lead people to seek out solace and support from their faith, and the ways religious resources and primary religious problems may ameliorate and/or exacerbate the trajectory of illness. Studies of religiousness defined globally by a few indicators such as frequency of prayer or religious affiliation should give way to more specific investigations of particular forms of religious expression among people grappling with specific forms of mental illness. For instance, when might religious conversion play a protective role against psychotic illness; conversely, when might it foster serious psychological problems? Do religious and nonreligious delusions and hallucinations have a different set of etiological factors and consequences? Fourth, additional studies are needed to answer key questions about the religious dimension of psychiatric care. Do spiritually integrated treatments enhance the effects of standard psychiatric treatment? What impact, if any, does religious similarity or dissimilarity between doctor and patient have on treatment process and outcome? What effects does psychiatric medication have on the religious problems, beliefs, practices, and experiences of patients? Fifth, for this area of work to advance, effective models of psychiatric training need to be developed, tested, and implemented (68,69). Finally, although theory, research, and practice in the area of religion and serious mental illness is still in its early stages, it is becoming clear that excellence in mental health care will involve the creation of respectful, collaborative relationships between psychiatry and the leaders and members of religious communities.

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