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 psychotherapy 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 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 scrutiny[1]. 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 decades. 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 importance[2].

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 life[3]. 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 tradition[4]. 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 religi-*

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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 goal[4].

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 health[5]. It is the outcome of various studies that physicians must consider the religious orientation of their patients while diagnosing and implementing treatment plans[6-9]. 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 them[10]. Earlier assessment of religious beliefs were considered unnecessary and inappropriate[11-12] while religious commitment has also been seen as few as a cause of future psychiatric disorder to come[13]. Even psychiatrists in the past have felt that religious commitment was irrelevant and even pathological in the clinical setting[14].

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 level[15]. 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 association[16]. 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 association[17].

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 article[18]. 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 spirituality[19].

Today clinicians must agree that patients may have different belief systems and faiths though all these systems 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 practices[20].

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 religiosity[21-22]. 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 abusers[23]. Numerous studies have predicted that religion separates those who do not take to substance abuse[24] and the same has been replicated in studies amongst adolescents[25]. 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 adolescents[26]. Community studies have shown a positive relationship between personal religious beliefs and reduced substance use amongst adolescents and adults[27]. However religious outlook has had little to do with substance abuse among those arrested for excess alcohol[28]. Religious coping mechanisms are also known to improve management of life events and thus reduces the risk of moving towards substance abuse[29].

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 depression[30]. A lack of spiritual support as denoted by low rates of church attendance has been associated with higher rates of depression[31]. 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 relationship[32]. High levels of spiritual and religious belief have been correlated with low suicide rate in the community[33]. 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 religiousness[34]. A review that analyzed sixteen studies on religion and suicide found that religious commitment was inversely related to the occurrence of suicide in 81% cases[35]. A nationwide increase in suicide rates with overall decline in church attendance rates has also been noted[36-37].

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 peers[32]. The religious involvement of the family has been found to play an important role in delaying sexual intercourse[38]. 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 pregnancies[39]. Religious orientation of parents influences the ideals about marriage, family size, power, intimacy, gender roles as well as methods of rearing and disciplining children[40-41].

Religion, Faith and Schizophrenia

Religious practices are common amongst schizophrenic patients all over the world[42-45]. 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 schizophrenia[46-49]. Religious practices in schizophrenic patients have been associated with a higher rate of developing religious delusion though not always necessary[50-51]. Many patients with schizophrenia take medications, visit psychiatrists and yet perform rituals and undergo exorcisms while they visit faith healers[52]. Religious commitment reduces the co-morbidity of substance use along with the occurrence of suicide in schizophrenia[53-54].

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 time[50]. 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 Japan[55], 21% in Austria against 6% in Pakistan[56] and 36% in USA[57]. 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 ascertained[58]. 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 recovery[59].

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 experience[60]. The right temporal lobe is seen to be activated in mystical states[61] versus the left temporal lobes that is activated in religious delusions[62]. The biological basis of spirituality lies in the serotonergic system[63]. There is also a specific 'God Spot' in the brain that is activated in spirituality studies[64].

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.

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