

The Faith of Patients

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Throughout my medical career I have been interested in the questions that patients ask about their illnesses. I work as a Liaison Psychiatrist and as an Honorary Consultant Palliative Care Physician in a local hospice. Many of my patients speak about suffering generally and some put their suffering into religious frameworks. I have found that religion and spirituality are prevalent coping strategies both for physical and for mental illness. My clinical experience has prompted me to examine the empirical literature on religion and coping with illness. Here I specifically focus on mental illness.

Both psychiatry and psychology have traditionally held a certain antipathy towards religion. Deriving from the writings of Freud in *Totem and Taboo* and *The Future of an Illusion*, clinicians have held religion to be a negative force in patients' lives, leading to guilt, dependency, obsessional behaviour and illusory beliefs. Where religion has been addressed by clinicians, it has been generally in terms of its differential diagnosis from psychopathology.

It is well recognised that clinicians are far less religious than the patients who consult them. There is a 'religiosity gap' between the two groups.

THE RELIGIOSITY GAP

Several studies highlight a "religiosity gap": psychiatrists are often far less religious than their patients (Kroll & Sheehan, 1981; Neeleman & Lewis, 1994, In a Gallup pole, one third of the general population in the USA considered religion to be the most important dimensions in their lives and another third considered it to be very important). In the United Kingdom, the 2001 Census revealed that 72% of the general public describe their religion as Christian.

Kroll, J. & Sheehan, W. (1981) Religious beliefs and practice among 52 psychiatric inpatients in Minnesota. *American Journal of Psychiatry*, **146**, 67-72.

Neeleman, J. & Lewis, G. (1994) Religious identity and comfort beliefs in three groups of psychiatric patients and a group of medical controls. *International Journal of Social Psychiatry*, **40**, 124-134.

On account of this, clinicians may fail to enquire about their patients' religious beliefs. This is a significant shortcoming, since for many patients with psychiatric disorders religion and spirituality play a significant role in their lives and may help them cope with their symptoms. It is important to differentiate

religion from spirituality since they are different and it is possible to be spiritual without conforming to any mainstream religion.

SPIRITUALITY/RELIGION

RELIGION

- Community focussed
- Observable, measurable, objective
- Formal, orthodox, organised
- Behaviour orientated, outward practices
- Authoritarian in terms of behaviours
- Doctrine separating good from evil

SPIRITUALITY

- Individualistic
- Less visible and measurable, more subjective
- Less formal, less orthodox, less systematic
- Emotionally orientated, inward directed
- Not authoritarian, little accountability

A number of empirical studies have demonstrated that patients with psychiatric problems commonly resort to religious coping. What appears to be important in terms of outcome is not religious involvement (e.g. church attendance) but how people actually deploy their religious beliefs to cope with adversity. Koenig et al. (1992) has found religious coping to be prevalent among hospitalised elderly men with life threatening illnesses in the USA. Furthermore, those who deployed religious coping experienced lower prevalence of depressive symptoms.

RELIGION AND COPING

Patients with psychiatric problems commonly resort to religious beliefs and practices in order to cope with illness.

Breakey W.R. (2001) 'Psychiatry, spirituality, and religion' *International Review of Psychiatry* 13, 61-66

Religious coping prevalent in acute/chronic physical illness

Koenig HG, Cohen HJ, Blazer DG, Pieper C, Meador KG, Shelp F, Goli V, Di Pasquale B. Religious coping and depression among elderly, hospitalized medically ill men. *Am J Psychiatry* 1992; 149: 1693-700

Religious coping can be positive (belief in a kind supportive God) or negative (angry with God, feeling that God has let you down). The former is associated with lower levels of psychiatric symptoms following life events compared to the non-religious population; whereas the latter is associated with higher prevalence of psychiatric symptoms (e.g. religious coping can have negative effects).

Koenig et al. (2001) describe the results of several thousand studies on religion and mental health. These studies are generally cross-sectional and therefore we cannot infer causation, but his review suggests that on balance being religious might lead to better mental health outcomes following adversity.

RELIGION AND MENTAL HEALTH

Koenig H, McCullough M, Larson D. *Handbook of Religion and Health*. Oxford: OUP, 2001:18

In the majority of studies, religious involvement is correlated with:

- Well-being, happiness and life satisfaction
- Hope and optimism
- Purpose and meaning in life
- Higher self-esteem
- Adaptation to bereavement
- Greater social support and less loneliness
- Lower rates of depression and faster recovery from depression
- Lower rates of suicide and fewer positive attitudes towards suicide
- Less anxiety
- Less psychosis and fewer psychotic tendencies
- Lower rates of alcohol and drug use and abuse
- Less delinquency and criminal activity
- Greater marital stability and satisfaction

There have been several recent studies of religion and depression that indicate:

1. Religious populations may experience lower prevalence of depressive symptoms
2. Religion may protect against the cognitive symptoms of depression rather than against the somatic symptoms
3. Religious involvement in those who are depressed may speed up the rate of remission of the illness
4. The relationships between depression, religion and mortality in physical illness remain unclear.

DEPRESSION AND RELIGION

Koenig HG (2007). Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. *Journal of Nervous and Mental Disease* 195: 389-395

In summary, patients who are highly religious by multiple indicators, particularly those involved in organized religious activities, remit faster from depression.

Koenig HG (2007). Religion and depression in older medical inpatients. *American Journal of Geriatric Psychiatry* 15 (4): 282-291

In summary, older medically ill hospitalized patients with depression are less religiously involved than non-depressed patients or those with less severe depression.

Blumenthal JA, Babyak MA, Ironson G, Thoresen C, Powell L, Czajkowski S, Burg M, Keefe FJ, Steffen P, Catellier D (2007). Spirituality, religion and clinical outcomes in patients recovering from an acute myocardial infarction. *Psychosomatic Medicine* 69: 501-508

No significant relationship was found between physical health outcomes ("events") and spirituality (measured using the 16-item Daily Spiritual Experiences Scale (DSE), frequency of religious attendance, or frequency of prayer/meditation. Religious attendance was significantly inversely related to depression and significantly related to social support, and total DES score was significantly and inversely related to depression. The authors concluded that there was no relationship between religious/spiritual measures and cardiac outcomes in this sample.

There have been few studies examining relationships between spirituality and depression. One study by Swinton (2001) indicates that spirituality may help the meaningless present in depressive illness.

SPIRITUALITY/DEPRESSION

Swinton J 2001 *Spirituality and Mental Health Care: Recovering a forgotten dimension*. London: Jessica Kingsley

His findings emphasised the importance of having meaning or purpose in their lives and how this sense of meaning was diminished by their illness. This loss and its associated rediscovery were central aspects of both depression and spirituality. Spirituality may provide such a sense of meaning through its emphasis on liturgy, worship and prayer found in the major religious traditions.

How might religion protect against the development of psychiatric symptoms?

HOW ARE RELIGION/SPIRITUALITY PROTECTIVE?

- a. Cognitive appraisal
- b. Provision hope
- c. Supportive God
- d. Religious community
- e. Less self centeredness

1. Adverse life events may be appraised in a different way. Religion provides a meaning context in which adversity can be understood. For instance loss of a job might be seen as a test of faith or as a communication from God that something better will happen in the future.
2. Religion provides a source of hope. For instance, in Christianity and Judaism, no matter how bad the world is now, the current state will imminently change with the second coming of Christ or the Jewish Messiah
3. God is with you in your suffering. The belief in an omnipotent God who supports a person through a crisis can be psychologically beneficial.
4. The religious community can provide a powerful form of social support.
5. Those who are religious often turn outwards towards others, away from self -reflection and this may have beneficial effects.

There has been some initial exploratory work in patients with schizophrenia that suggests:

1. Religious beliefs are prevalent in the lives of those with schizophrenia
2. These beliefs might provide a source of hope
3. Religious strategies such as prayer may be useful for coping with symptoms such as voices.

RELIGION AND SCHIZOPHRENIA

Sylvia Mohr, Pierre –Yves Brandt, Laurence Borrás, Christiane Gilliéron, and Philippe Huguelet. Toward an Integration of Spirituality and Religiousness Into the Psychosocial Dimension of Schizophrenia. *Am J Psychiatry* 2006 163: 1952-1959.

Semistructured interviews about religious coping were conducted with a sample of 115 outpatients with psychotic illness. For some patients, religion instilled hope, purpose, and meaning in their lives (71%), whereas for others, it induced spiritual despair (14%). Patients also reported that religion lessened (54%) or increased (10%) psychotic and general symptoms. Religion was also reported to increase social integration (28%) or social isolation (3%). It may reduce (33%) or increase (10%) the risk of suicide attempts, reduce (14%) or increase (3%) substance use, and foster adherence to (16%) or be in opposition to (15%) psychiatric treatment.

To date these studies have been conducted in the Sweden and there is little work from the UK.

It is important to emphasise that the psychological effects of religion are not always positive and that there may be negative psychological outcomes.

THE NEGATIVE EFFECTS OF RELIGION

- a. Guilt
- b. Dependency
- c. Obsessions
- d. Suicide
- e. Marital disharmony

1. Some religious groups such as Orthodox Judaism and Catholicism may engender guilt and thus may be detrimental psychologically.
2. Long term involvement in a religious group may predispose to dependency on religious leaders.
3. Religions which emphasize rituals, such as Islam and Judaism, may predispose to obsessional behaviour.
4. Members of some extreme New Religious Movements (e.g. Heaven's Gate, Branch Davidians) may predispose their members to suicidal behaviour
5. Where couples come from different religious backgrounds, there may be disagreements over religious doctrines and child upbringing leading to marital disharmony.

What should be the areas for future research?

FUTURE RESEARCH

- a. Non-Christian groups
- b. Relationships between ritual, prayer, doctrine and mental health
- c. The mental health effects of religious experiences such as mysticism
- d. Efficacy of religiously based therapies
- e. Understanding complex links between the neurocognitive/neuropsychological aspects of religion and mental health

1. There is a need to examine non-Christian populations since most of the current research has concentrated upon American Christian groups
2. There is a need to move beyond religious involvement and examine religious practices such as prayer and rituals and their mental health implications.
3. Religious experiences and their relationship to mental health warrant further investigation
4. To date there have been few studies of religiously-based therapies for religious patients. In one study of Christian-based healing (Propst 1992), the addition of a Christian-based framework to CBT enhanced the efficacy of this modality of healing among Christian patients.
5. Recent advances in MRI/SPECT scanning can be deployed to examine the complex links between religious experience and psychopathology.

Finally what are the clinical implications of the above findings? Patients commonly use religious strategies to help them cope with their psychiatric symptoms. Clinicians are surely obliged to inquire about their patients religious lives in an attempt to facilitate self directed healing. Indeed, some studies indicate that patients are keen for their physicians to inquire about religion.

DO PATIENTS WANT DOCTORS TO ASK ABOUT SPIRITUALITY?

- King, D.E., Bushwick, B. (1994) 'Beliefs and attitudes of hospital in-patients about faith, healing and prayer', *Journal of Family Practitioner*, 39:349-52
- Anderson, J.M., Anderson L.J., Felsenthal, G. (1993) 'Pastoral needs for support within an in-patient rehabilitation unit', *Archives of Physical Medicine Rehabilitation*, 74:574-8

Presentation given at the Annual Meeting of the Royal College of Psychiatrists, Liverpool, June 2009