

Spirituality and religion in psychiatry: an introduction to the research evidence

Talk given at the Royal College of Psychiatrists' Annual Meeting, 29th June 2011, on the theme of 'Spirituality: its evidence and implementation in psychiatry'

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This talk has several learning objectives listed below:

- ▣ Methodological issues in spirituality and religion (S/R) research will be considered
- ▣ Concepts and definitions used in S/R research will be examined
- ▣ Studies examining the association between suicide, depression etc. and S/R will be discussed
- ▣ Issues for consideration in future research will be examined

A paper such as this cannot explore the existence of God or whether religion is irrational or otherwise. Moreover it is limited in its scope to deal with the range of psychiatric conditions in which religion has been investigated and shown to be of relevance.

From ambivalence or even hostility to religion, there has been a surge of interest in the role of spirituality/religion (S/R) in mental health and illness. The American College of Graduate Medical Education in its Requirements for Residency Training in Psychiatry states that all programmes must provide training in the role of religious and spiritual factors in psychological development. The Royal College of Psychiatrists (2011) published a four-page position statement on the adopted position that 'there is now a sufficient body of evidence to suggest that spirituality and religion are at least factors about which psychiatrists should be knowledgeable insofar as they have an impact on the aetiology, diagnosis and treatment of mental disorders. Further, an ability to handle spiritual and religious issues sensitively and empathically has a significant potential impact upon the relationship between psychiatrist and patient'. There are now also a number of peer reviewed journals dedicated to publishing on the topic. These include the Journal of Health and Religion and the Journal of Spirituality in Mental Health, to name but two.

Association or causation?

While it is recognised that there is an association between mental health and religion, it is unclear if this is a causal one. It may be that those who are mentally well are better able to attend religious services, rather than religious practice itself predisposing to better mental health. A second relevant question is whether this benefit comes simply from the support and friendship that religious attendance is likely to generate. If this is true than being a member of a football club could have the same effect. A further possibility is that the benefits

may accrue from the lifestyle that those with S/R interests may lead. The benefits of moderation in using substances, the physical benefits of prayer/mediation and the associated limits on risk taking may be the main contributors. Fourthly, the possibility that these benefits are linked to hope, meaning and purpose generated by, in particular, religious activity should also be considered.

In order to answer the question of association or causality studies must adhere to the criteria enunciated by Bradford Hill (1965).

So studies must use different designs and different population types e.g. community samples and those with mental health problems in a variety of clinical settings; there must be control for confounders such as social supports and prior and current physical and mental health. Cross-sectional studies are limited in their ability to show causality and longitudinal investigations are required.

Constructs and dimensions used in S/R research

When examining studies on religiousness and spirituality, there is frequently conflation of the two constructs. This is increasingly a problem since there is now evidence that they two are no longer overlapping domains, as was previously assumed, but are quiet distinct (Zinnbauer et al. 1997) with possibly different influences on mental health.

Religiousness can be defined as a set of beliefs, practices and rituals related to the Sacred, that has developed out of a tradition with common beliefs and practices concerning the Sacred. The definition of spirituality is vaguer, and while some believe that it should be grounded in the Sacred (that which related to the numinous - mystical, supernatural, God, The Ultimate Truth or Reality) while others choose a more secular definition.

Turning to measures used in S/R research, further related problems arise since some of the measures of equate spirituality with mental well-being.

For example, the most widely used measure of S/R is the Functional Assessment of Chronic Illness – Spiritual Well-Being (FACIT-SP) (Brady et al. 1999). It contains statements such as 'I feel peaceful', 'I have a reason for living', 'I feel a sense of harmony within myself'. These are clearly measures of mental well-being and any study purporting to use this as a spiritual measure will clearly find a strong positive association between both. Similar criticisms apply to the World Health Organisation Quality of Life measure (WHOQOL) and to Multidimensional Measure of Religiousness /Spirituality (Fetzer Institute 1999).

The most appropriate approach is to use different measures of spirituality and religiousness. King et al. (2001) have developed one such measure, The Royal Free Interview for Spiritual and Religious Beliefs. This measure provides clear and comprehensible definitions of religiousness and spirituality. For the measurement of religiousness the DUREL scale (Koenig et al. 1997) is easy to use and has good psychometrics. While DUREL measures three dimensions, Kendler (2003) developed a scale which measures seven; these are: general religiosity, social religiosity, involved God, forgiveness, God as judge, unvengefulness and thankfulness.

Another construct used in S/R research is that of intrinsic and extrinsic orientation (Allport 1950). Intrinsic orientation is directed toward God and internalises the ethics and practices of

religion as a guide to living. On the other hand extrinsic orientation professes religious beliefs to appear respectable, to gain social advancement, or due to convention and it does not internalise religious values as a code of conduct.

Religious coping is another term that appears in the body of research and the idea was developed by Pargament et al. (1988). He described three styles:

- collaborative
- self-directing
- deferring

In the collaborative style, the individual takes joint responsibility with God for problem-solving. On the other hand, the self-directing style derives from the person's belief that God has given them agency over their lives and that this results in the individual taking complete responsibility for finding solutions to problems. Finally, the deferring style passes the responsibility completely to God while passively waiting for solutions. Those using the first approach have been found to result in lower levels of depressed mood under conditions of high stress than the latter two. Although not regarded as an effective coping style generally, the deferring approach has been shown to be helpful when the person has little control over the circumstances/outcome of the stressor, and handing responsibility over to a Loving Being may enhance feelings of empowerment.

As well as considering specific religious coping styles in approaching life's problems, it is relevant also to consider how these problems might be *interpreted* by those of a religious persuasion so as to reduce their negative impact. This is termed 'cognitive appraisal.' Religion may allow people to attach a 'purpose' or meaning, to their suffering, rather than simply feeling hopeless or helpless. Most religions do not always see life's problems, even those that are grave, as destructive, and may view negative events as having a higher value from which people can learn, e.g., having made a mistake in life they can learn from it for the future (although this is obviously not a uniquely religious attitude). Others believe that difficult though their problems may be, there are those are much less well off, or they may regard suffering as making them more compassionate and understanding of the troubles of others. Some draw strength from their specific belief in the love of Christ who Himself suffered and understands their needs during the present difficulties. Religiously determined cognitive appraisals are presently being developed for use even in secular therapeutic settings.

There is evidence that positive religious coping is prominent in those with long-term mental illness, with large numbers spending a significant amount of time in prayer (Tepper et al. 2001). For example, meditation and religious activity were identified as particularly helpful in a group with bipolar disorder (Russinova et al. 2002). Of 406 people surveyed having long-term mental illness, 80% used religious coping, 61% spent more than 50% of time in religious coping, e.g. prayer, and large numbers reported religious activities as the most beneficial alternative health care intervention.

Association between S/R and mental health

There are now hundreds of studies examining the relationship between various aspects of mental health and S/R. Koenig (2009) found that 476 of 724 studies reported statistically

significant positive associations between religion and mental health prior to 2000. They have covered diverse areas on mental health and illness. A few samples will be provided below since space precludes descriptions of the range of psychiatric disorders that have been studied. The reader is referred to Koenig and McCullough 2001 for a more comprehensive review.

Depression:

A meta-analysis by Smith et al. (2003) identified 147 studies. A modest effect size (-0.096) for the overall association between depression and religiousness was identified. Excluding zero effects, 81% of studies were negative, i.e. as religiousness increased depression decreased, and 27% were positive (-0.54 - 0.24). There was a positive association between depression and extrinsic religiousness and between negative religious coping and depression. Both main effects and a stress buffering hypothesis were supported.

Among those with depression in medical settings, in a study by Koenig et al. (2007) 1000 in-patients with CCF or pulmonary disease, diagnosed using SCID were compared with non-depressed in-patients. Controls were in place for demographics, health and social factors. Those with depression more likely to indicate no religious affiliation, to be 'spiritual but not religious', were less likely to engage in prayer or Bible reading and had lower intrinsic religion scores. There was no association between religion and depression type but greater severity was related to lower levels of religious practice. The groups were followed for 12 - 24 weeks and remission from depression was 53% faster in those who were the most religious after demographic, social, psychiatric and physical health predictors of remission controlled.

Even at the severe end of the spectrum, for 104 in-patients with depression whose symptoms were assessed at baseline and 6 months, using MADRAS positive religious coping predicted significantly less depression at 6 months and this was independent of social support, demographic, use of ECT or number of prior depressive episodes (Bosworth et al. 2003).

Similar findings have been identified in population level studies. For example, in two separate longitudinal studies of over 70,000 adult Canadians, it was found that formal involvement in worship had lower odds of depression after controlling for cofounders, while those who perceived themselves to be religious/spiritual showed higher odds of psychiatric disorder (Baetz et al. 2004; 2006)

Suicidal behaviour:

A systematic review (Koenig and McCullough 2001) identified 68 studies examining suicide-religion relationship of which 57 found fewer suicides or more negative attitudes among the more religious. Nine found no relationship and 2 mixed results. In relation to suicidal behaviour, among depressed in-patients with similar severity of depression and hopelessness, those who were religiously unaffiliated reported more lifetime suicide attempts and more 1st degree relatives who died by suicide when compared to their affiliated counterparts (Dervic et al. 2004). Possible explanations for the protective effect of religious beliefs against suicidal behaviour are the supportive offered by the community to those who are religious (Dervic et al. 2004), the prohibition against suicide (Van Tubergen et al. 2005),

moral objections (Dervic et al. 2011) and the meaning that religion provides (McLain et al. 2003).

Psychosis:

While many people with psychosis experience religious delusions, the role of religion in its aetiology and prognosis has received little attention. This is surprising since several studies (Huguelot 2006; Mohr 2007, Mohr 2006) have confirmed the importance of religion in the lives of this group of patients, yet less than half discussed it with the psychiatrist.

There is some evidence that those with predominantly religious delusions are more functionally impaired than those with other delusions (Siddle et al. 2002) while the impact of non-psychotic religious activity on prognosis has been mixed (Schofield et al. 1954).

Work in progress

A midpoint analysis (Casey personal communication 2011) in a study of depressive disorders (depressive episode and adjustment disorder) has identified personality and frequency of religious attendance as associated with severity of depression. The study population consisted of inpatients and outpatients diagnosed in a consultation liaison setting. Controls for third variables such as age, social supports, gender and life events were carried out. The results showed that the greater the frequency of religious attendance the lower the depression score.

Conclusion

The position statement of the Royal College of Psychiatrists, its first on this subject, is timely in light of the rapidly expanding literature linking S/R activities to positive mental health. Future research should separate spirituality from religiousness in order to examine any differences or similarities in their respective impact on mental health. Causality between S/R activity and positive mental health is not yet definitive but there are strong pointers in that direction.

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