Religion, Spirituality, and Mental Health

7

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Introduction

The relationship between religion and mental health varies by class, gender, religious denomination, and other factors. The most accurate predictor of religiosity is geography. While religious identification is declining in Western Europe and North America, it is growing in other regions. In Pew Research Center telephone surveys conducted in 2018 and 2019, 65% of American adults described their religious affiliation as Christian, which illustrated a 12% decrease over the past decade [1]. Meanwhile, the religiously unaffiliated share of the population, including those who selected atheist, agnostic or "nothing in particular," increased to 26% from 17% in 2009 [1]. It is important to recognize that those who identify as atheist or agnostic might still consider themselves to be spiritual. In addition, those that consider themselves to be religious might be "culturally religious," where they participate in the traditions of their religion (e.g., Shabbat dinner on Friday), but may not be traditional "true" believers. In contrast to Western Europe and North America, 84% of the world's population identifies with a religious group [2]. Members of this demographic are generally younger and produce more children; thus religious identification continues growing worldwide.

Until the early nineteenth century, psychiatric disorders were managed and treated by religious leaders. A major change occurred when Charcot and Freud associated religion with hysteria and neurosis. This created a divide between religion and psychiatry, which has only started to change in the past few decades. One

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sign of change was in 1994 when the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) included the V-code of "religious or spiritual problems" with the purpose of helping professionals better understand their patient's beliefs and rituals. The current DSM-5 recommends this V-code "category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution" [3]. Additionally, religious elements may be a symptom of several diagnoses or affect how symptoms are interpreted (e.g., hallucinations may be culturally normative in some religions).

There is wide acceptance that religiosity plays a role in the presentation and treatment of psychiatric diagnoses, but how much of a role, and to what degree, remains unclear. Religion provides us parameters for what a religious client may need in terms of support. Spirituality is more subjective and has no clear guidelines for what a patient believes in, how they view mental health, medications, and the level of need necessary for support. While these are separate belief domains, they often go hand in hand when understanding support needs. If a patient was not religious before onset of symptoms, do we chalk up the religiosity as a symptom of mental illness or treat the person using religion as a protective factor? When is religiosity determined to negatively impact mental health functioning, and when is it incorporated into treatment planning and positive coping mechanisms? Also, who are mental health experts to decide what is hyper-religiosity or not, and if it is disordering a patient's life? Culture is decided by the people within it; if someone's religion or spiritual beliefs no longer fit, is that a disorder? Like with all things, there is a spectrum that describes the relevance of spirituality and religion in the context of a culture. On this spectrum, the majority of individuals linger close to the median and have some faith basis or spirituality structure in their lives. Those who flank the ends of the spectrum hold religion as a large cornerstone of their daily functioning or do not view religion or spirituality as any part of their life. It is essential to find out for each individual person their need and level of support.

Even though religious belief is the majority worldwide, physicians in psychiatry are much less likely to believe in God or be affiliated with a specific religious organization [4]. Compared with other physicians, psychiatrists are more likely to be without religious affiliation (17% *v*. 10%), less likely to believe in God (65% *v*. 77%), less likely to attend religious services at least twice monthly (29% *v*. 47%), and less likely to rely on God for strength and support (36% *v*. 49%) [4]. However, it would be a gross mistake for mental health providers, including psychiatrists, to disregard religion and spirituality when considering treatment because of their personal biases in this area, given the prominence within patient populations.

Religious beliefs can be associated with both positive and negative psychological effects. A negative psychological effect of religious involvement manifests with excessive devotion to religious practice that may result in family discord, particularly in areas of sexuality. Speaking broadly, religion places an emphasis on guilt, sin, and a disregard for personal individuality and autonomy. Positive psychological

effects of religiosity increase with being active in one's religious organization. Positive outcomes include a greater sense of optimism and hope, self-esteem, meaning and purpose in life, increased social support, a decrease in suicidality, and higher marital satisfaction [5].

Background

Religious affiliation creates a shared culture affecting one's beliefs, practices, routines, responsibilities, and attitudes. Paul Tillich, one of the most influential theologians of the twentieth century, stated:

> Religion as ultimate concern is the meaning-giving substance of culture, and culture is the totality of forms in which the basic concern of religion expresses itself. In abbreviation: religion is the substance of culture; culture is the form of religion. Such a consideration prevents the establishment of a dualism of religion and culture. Every religious act, not only in organized religion, but also in the most intimate movement of the soul, is culturally formed [6].

Religion is specific to different geographical cultures, and it does not easily translate between cultures. Even when missionaries convert different regions of the world to a different religion, there is variation in the religious practices between the converts and the original.

Throughout human history, many cultures have viewed mental illness as a form of religious punishment or demonic possession. During the Neolithic Era, primitive humans would chip a hole into the skulls of mentally ill individuals to release the evil spirits. Ancient Hindu and Punjabi scriptures attribute anxiety and depression, in part, to disrespecting the gods. In ancient Mesopotamia, priest-doctors treated mentally ill individuals with rituals to drive out evil spirits. In ancient Egyptian, Indian, Greek, and Roman writings, mental illness was characterized as a personal or religious dilemma. In ancient China, the mentally ill were concealed by their families for fear that the community would believe that the affliction was the result of immoral behavior by the individual and/or their relatives.

Hippocrates, a Greek physician who is considered the "father of medicine," was the first to attribute the cause of mental illness to natural occurrences in the human body, particularly pathology in the brain, rather than supernatural forces. During the Middle Ages, mentally ill individuals were believed to be possessed by a demon. Conceptions of madness in the Middle Ages in Europe were a mixture of the divine, diabolical, magical, and transcendental. Madness was thought to be a punishment for sin or a test of faith and character. Hebrews believed that all illness was inflicted upon humans by God as punishment for committing sin, and since Hebrew physicians were also the religious leaders, the treatment did not proceed further. Arab historic texts contain discussions of mental disorders, where some thought they were caused by possession by a djinn (genie), which could be either good or demon-like. Christian theology endorsed various therapies, including fasting and prayer for those estranged from God and exorcism for those possessed by the devil.

Throughout history and modern times, religion has been profoundly intertwined with mental health. Religious preoccupations in obsessive-compulsive disorder (OCD), hyper-religiosity in mania, and delusions of omnipotence are all known psychiatric symptoms. The very nature of these religious experiences is considered pathological. At the same time, religious beliefs and being part of a religious organization are considered protective when assessing suicide risk factors. Belief in God has shown to be comforting to those struggling with anxiety and depression. This complicates things, because it is up to mental health providers to decide when the client's religion is pathological, protective, neither, or both. To address this, clinicians are encouraged to do the following:

1. Obtain information about patients' religious and cultural values.
2. Liaison with one or more well-informed members from the same cultural-religious background.
3. Consider whether religious functioning is problematic.
4. Consider whether religious functioning has been affected by psychopathology.
5. Consider how religion is being used in coping, attending to contextual factors.

Vignette 1

George is a 22-year-old Filipino American male with no previous psychiatric history who was referred to an outpatient clinic after initially presenting to the emergency room for missing several weeks of class. George, along with his family, had always been very active in the Catholic Church. Religion is a large part of his Filipino culture, so he regularly attended youth group and Sunday Mass and served as an acolyte. His family participated in daily devotional prayer, and he was encouraged to attend confession. George was baptized as an infant and attended confirmation preparatory classes. When George entered his teenage years, he would occasionally express desire to skip church with his family Sunday mornings, stating he would rather relax or study. During George's third year in college, he started reading the Bible nightly. This progressed from a devotional in the evening to several hours every day. His family often noticed him in the backyard using his rosary. Eventually, his mother heard from their priest – George attended confessional at the cathedral so often that he was missing classes. By then, his grades started dropping and his parents insisted that he seek assessment. When he finally presented to clinic, a semi-structured interview with George and his parents, as well as the Yale-Brown Obsessive Compulsive Scale was administered, and he was given a diagnosis of OCD. George was started on sertraline and referred for Exposure and Response Prevention (ERP).

This case highlights several important points – often, nonpathological religious practices can precede pathology. Along the continuum, when should a mental health provider intervene?

Culturally Competent Care

The traditional model of culturally competent care is to ask about religion as a check box item and to be cued into any typical alerts. For example, if a patient identifies as Jehovah's Witness, this alerts the provider to be aware of certain medical restrictions, specifically, in regard to blood transfusions. However, more subtle nuances of religious and spiritual beliefs hold just as much importance to culturally competent care.

When caring for clients, it is important to consider a "person in environment" approach. It would not make sense to treat a person in a silo without considering their family and societal systems. Clinicians must ask themselves – what is the norm for that person's environment and what do they view as important? As a clinician, it is vital to not only speak with the patient but also their family, if possible. Do their religious/spiritual practices look similar or different than their family/friend group? When determining pathology, this is an important factor to consider. While something might seem extreme to one person, viewing it in context provides a clearer picture. An example of this is the Hasidic Orthodox Jewish population. If, without context, you had a patient from this religious group share that they pray multiple times a day, before handwashing, meals, when waking up, and when going to bed; that they cannot have certain foods touch or eaten at the same meal time, that they even have separate sinks, plates, and silverware; and that they must wear their hair in a certain way and cannot go in public if part of their head is not covered, this may sound like the beginnings of an OCD diagnosis. When considering this person's behavior in the context of their community, it does not seem strange or pathological. Instead, they fall within the normal standards set by their religious beliefs and community. If this same person presented in your office and all these behaviors were new onset, they were not part of the Hasidic community; then considering pathology would be indicated, especially if these new behaviors were hindering daily functioning. In the Jewish population, none of these behaviors are an issue with how their community and society function, but if this were one person in a different community, it could cause alarm.

When meeting with a patient for the first time, it is valuable to collect a comprehensive history of not just pathology but their strengths, support systems, coping mechanisms, and their outlets of joy. These are essential to understand how they view their life. Also, this information lays the groundwork for helping that person successfully reenter their life with appropriate supports and tools. Obtaining a comprehensive view of a person's culture lays the foundation for treatment. If they find strength in religion, providers can encourage them to connect with an organization that aligns with their belief system or assist them to incorporate the religious or spiritual components that bring them solace.

Understanding the versatile language used is also important as there are no set parameters for the terms "religion" and "spirituality," or how individuals refer to the practices associated with their beliefs. Important information to collect

includes learning what a patient calls their belief system, how they refer to a higher power, if they use prayer/meditation, and what religious rituals they engage in. One client might refer to sitting on the ground in silence with mandala beads as meditation, while another might consider that prayer. In a more literal sense, language can be a huge barrier when explaining psychiatric illness, treatment, and medications. A barrier that becomes extremely difficult when coupled with a religious undercurrent. A simple translation usually will not provide complete care. When explaining a serious mental illness to a patient and their family, it is important to have an in-person interpreter who is able to provide cultural context of the religion and belief system of that culture in relation to psychiatric illness. Understanding the difference between being culturally religious and practicing set religious guidelines is an important concept when treating the patient through a culturally competent lens. While traditions are important to the fabric of societies, people who identify with a religion sometimes only do so in a "culturally religious" way. For instance, they might decorate a Christmas tree and hide Easter eggs for their children, but they do not use religion as a source of support or guidance. Knowing this distinction can help guide treatment, and a clinician, in this instance, would be advised to not place significant emphasis on religion when discussing resources in the community.

Not every clinician is expected to be an expert on every religion, subgroup, and spiritual practice. Therefore, it is important to use one's network and resources. Knowing one's limitations, or practicing cultural humility, is vital to providing culturally competent care. For example, a psychiatric team had difficulty communicating the importance of outpatient treatment for a child to the family. The parents did not speak English and were devout in their religion. It was not until they found a community clinic specific to Southeast Asian families that the parents began to engage more in treatment. This community clinic had clinicians who could speak multiple languages native to Southeast Asia and had a shared cultural-religious foundation. In regard to treating a patient through the cultural lens of religion or spirituality, it is necessary to consider how a patient copes and from where a patient draws their strength and resiliency. Even when treating a patient with hyperreligiosity and grandiose thoughts, it is important to not completely disregard these in the treatment. Sometimes a symptom of illness is part of the cure. For example, if reading scripture provides a person peace but was previously used as an avoidance mechanism or became intrusive in their daily functioning, acknowledging the importance of this behavior may be helpful to structuring a more balanced life. The patient may benefit from incorporating it into their day, after completing a needed task, which can provide the patient assurance that their provider views their values and beliefs as important. Consulting with a trained member of the clergy, such as a hospital chaplain, can help a patient parse out how their belief system fits. Often, after a patient in a manic episode or dealing with OCD receives medical treatment, their obsessions or delusional thoughts become less intense. The care and acknowledgement they receive about their beliefs are important to the lifelong sustainability with treatment of their illness.

Vignette 2

Claire is a 12-year-old girl who presented to the hospital for disorganized behavior, hyper-religiosity, and self-injurious behavior. Her injuries were not life threatening, and they were not done with intent to die. Prior to admission, Claire had a diagnosis of attention-deficit/hyperactivity disorder through her school, but she never received psychiatric treatment or medication. She was a typically developing preteen enrolled in a public school in an upper middle-class neighborhood. Claire had a group of friends at school, performed average academically, and attended a youth group at her church. The most recent and pertinent stressor was that her parents separated and lived in different homes. Claire was splitting time evenly between the two households, but due to proximity to her school, she spent most nights at her father's house. Claire's parent brought her to the hospital due to her lack of interest in sleeping, eating, or caring for basic activities of daily living (ADLs). At home, she would climb onto the roof and shout down to cars and passersby religious statements such as "Jesus loves you. Jesus saves." Her parents shared that while the family attended church weekly, they were not extremely religious and never used the phrases the patient shouted. Claire made signs with similar messages to give to people in the neighborhood and to decorate her room. She would shout from her bedroom window day and night resulting in neighbors filing multiple police reports. This behavior was consistent across both parental households, and she stopped attending school several weeks prior to admission.

While in the hospital psychiatric unit, she continued with her erratic behavior, making signs and laying them out in her room in a pattern that could not be disturbed. If the pattern was not "correct," she claimed "the devil would attack" and everyone "would go to hell." Any disruptions to her drawings, signs, and shouting statements caused her distress and concern that the devil would hurt her family and that Jesus would be mad at her. The hospital chaplain met with her in an effort to provide context and comfort, but she was unable to engage productively. She asked insightful questions, but she did not believe the responses if they contradicted her own beliefs. Claire continued to sleep poorly, poor food intake, and needed assistance in completing ADLs in the hospital. Due to Claire's age, staff not only needed parents' permission to medicate but also wanted Claire to assent. Claire's assent was important because without her willingness the likelihood of medication compliance outside of the hospital would be low. After initial discussions, the patient agreed and was started on fluvoxamine to treat her OCD. With medication, better sleep, and ERP therapy, Claire was able to improve her daily functioning and was discharged after 10 days. She was still religiously occupied, but it became a source of comfort instead of a compulsion causing distress.

This case required family input to obtain background information on religious and spiritual needs. The hospital chaplain added the element that the patient is her own autonomous person and her beliefs are valued by the medical staff. While religiosity was a symptom of her OCD, it was also used as part of her treatment to distinguish between shared beliefs and her own obsessions and compulsions.

Training and Education

The first step in evaluating patients is simply obtaining information. As much as possible, the practitioner should maintain a neutral and accepting viewpoint. Consider starting with questions such as the following:

- Are you a member of a religious community?
  - If yes, follow-up questions include:
    How active are you?
    Do you receive support there?
    How does this community feel about your psychiatric treatment?
  - If no, follow-up question:
    Do you have any spiritual beliefs that have shaped your experience?
- Are there religious or spiritual beliefs in your family (even if this is not your personal belief)?

It is important to demonstrate respect for the patient's religious or spiritual beliefs, avoid abrupt transitions from inquiry to support, and adopt a respectful and but neutral position. Even bizarre or clearly pathological religious beliefs should be handled with respect and providers should attempt to understand them. If beliefs do not appear obviously pathological and appear to facilitate coping, then the clinician should consider supporting them. It may be necessary to gently challenge beliefs that are used defensively to avoid making important life changes or attitudinal shifts. If providers assess that certain beliefs should be challenged, a therapeutic alliance is critical. Providers should consult the patient's clergy, if the patient agrees, before challenging beliefs, and discuss why certain aspects appear to be pathologic. Prayer should only be done if the patient initiates a request for it, the psychiatrist feels comfortable doing so, and the religious backgrounds of patient and psychiatrist are similar.

Problems of religion and mental illness may exist together or separately. There are three different types of religious problems that could involve mental health issues:

1. A religious problem with no other psychopathology – for instance, an individual who is anxious about their ability to tithe or volunteer at their religious organization. In this case, the appropriate intervention would be seeking counsel within their religious organization.
2. Parallel religious and mental health problems – for instance, an individual who struggles to maintain their faith after a trauma but also meets criteria for post-traumatic stress disorder (PTSD). In this case, individuals should work concurrently with a mental health practitioner and a religious leader.
3. Religious problems stemming from psychopathology – for example, an individual who seeks confession hourly due to compulsive behaviors associated with OCD – in these cases, providers should focus predominantly on mental health treatment.

When religious issues originate from a mental illness, providers should use a semi-structured interview along with the DSM-5 to determine the appropriate diagnosis. It is important to assess adaptive functioning (preceding and following the religious experience), determine whether symptoms are acute or chronic, maintain a level of openness to exploring spiritual experiences, compare idiosyncratic behavior and beliefs to normative practices in religious/spiritual community (e.g., speaking in tongues, hearing the voice of God), and recognize that psychopathology is often characterized by greater intensity, terror, and decompensation than genuine spiritual experiences. Questions a clinician can ask themselves to lead to the appropriate differential include:

1. Do current behaviors/practices exceed religious injunctions?
2. Does client overemphasize certain practices or beliefs and neglect others?
3. Do beliefs and practices promote wholeness, relatedness, and full humanness?

Disorder Specific Considerations

There are several disorder specific considerations when examining the relationship between pathology and religious and/or spiritual beliefs. Studying this topic presents with many challenges. First, because religious beliefs cannot be randomly assigned to people, research studies are primarily observational and correlational and cannot assume causality. Additionally, determining the amount of religiosity is subjective and self-reported. There are limited quality assessments to measure these concepts and lack of standardization across the field. Furthermore, an individual often has changes in the strength of their religious beliefs throughout their life and periods of increased or decreased involvement within a religious organization and/or community. Individuals that identify or associate with an organized religion have been studied significantly more than those that identify as being spiritual. Therefore, while several studies demonstrate an association between religious or spiritual beliefs and mental health, there are no causal studies, conclusions may be unreliable, findings are nuanced, and studies must be interpreted with these limitations in mind.

Substance Use Disorders

Given that most religions actively discourage the use of substances, it is unsurprising that studies generally indicate negative associations between substance abuse and religious involvement. In a review of 134 studies that examined the relationships between religious involvement and substance abuse, 90% found less substance abuse among the more religious [7].

The majority (nearly 75%) of substance abuse treatment centers use a 12-step model, which involves a religious component. Alcoholics Anonymous (AA) originated the idea for the 12-step model in 1938, when founder Bill Wilson wrote out

the ideas that developed through his experience with alcoholism and other alcoholics. He wrote about the positive effects experienced when people struggling with alcoholism shared their stories with one another. Even though success rates in treating substance abuse disorders are low, 12-step programs are more successful than other models. Within the 12 steps, God or a "power greater than ourselves" is mentioned numerous times [8].

Many outpatient and residential substance use treatment programs may incorporate religious elements, such as required attendance of a 12-step program. It is critical to first ask in a neutral and direct manner what the patient's underlying belief system is. When a provider encounters someone resistant to the concept of God or a higher power (for whatever reason), it is important to underline that "God" is a loose term used to represent anything greater than the alcoholic or addict as an individual. Additionally, patients should be made aware of other evidence-based nonreligious support groups, such as Self-Management and Recovery Training (SMART Recovery). Asking about patient's religious beliefs can help inform treatment, prime patient's for appropriate expectations, and utilize religion as a source of strength, support, and resources.

Psychotic Disorders

In hospital settings, one of the hallmark questions to screen for psychotic symptoms is, "Do you hear or see things that other people don't?" If a patient reports that they hear voices when nobody is present, this may indicate the use of an antipsychotic medication. However, certain religious followers pray in order to hear God's voice talking to them. They believe they can hear God, speak directly to God, and this is shared with other members of their religious belief system.

Numerous studies have tried differentiating between schizophrenic or delusional thoughts and religious beliefs. Studies found that there are specific qualities to the visions, voices, and delusions of the psychiatrically ill, even before the onset of the illness [9]. Even when the content of their hallucinations may be influenced by religious ideas or cultural variability, specific qualities including intensity, lack of controllability, and unpleasantness, are more likely to be the result of a psychotic process rather than a religious one.

When psychosis follows a religious experience, the psychosis is more likely to be associated with a mood disorder (e.g., mania) rather than schizophrenia. Moreover, it is likely that the person was a vulnerable individual, with a past history of either psychosis or a premorbid personality. Studies that evaluated the themes of various religious/spiritual delusions report that the most common themes are of persecution by malevolent spirits, being controlled or influenced by spirits, and delusions of grandiosity where the individual feels they are a prophet [10]. Studies also suggest that religious delusions are held with more conviction and pervasiveness than other delusions [9].

Interestingly, the prevalence of religious delusions and hallucinations in patients with schizophrenia varies from country to country. One study reported a higher

incidence of religious delusions among schizophrenic patients in predominantly Christian countries than in other populations [11]. Cross-cultural studies that compared people from different ethnic backgrounds suggest, in case of paranoid delusions, Christian patients more often report persecutors to be supernatural beings, compared to Muslim and Buddhist patients [11]. The authors posited this may be due to Christianity being more focused on guilt and forgiveness of sins [11].

Trauma- and Stress or-Related Disorders

Extant literature related to the interaction of religious/spiritual beliefs and trauma- and stress or-related disorders is minimal and with mixed findings. Although some studies found that religion is positively associated with the ability to cope with trauma and may deepen one's religious experience, other studies found that religion has little or negative effects on symptoms of PTSD [12]. One possible explanation for this is that a traumatic event can affect a person's core beliefs and alter their relationship to religion. Potentially moral injurious events can cause psychological distress and completely restructure a person's moral framework [13]. This would differ from person to person as the criteria of an event qualifying as morally injurious is determined by a person's value structure.

Anxiety Disorders

Some studies have examined the relationships between religiosity and specific anxiety disorders such as OCD and generalized anxiety disorder. Contrary to the views of Freud, who saw Western religion as a form of universal obsessional neurosis, empirical evidence suggests that religion is associated with higher levels of self-reported obsessive-compulsive personality traits, but not with higher levels of OCD symptomatology compared to the nonreligious [14]. Religion may encourage people to be scrupulous, but not to an obsessional extent.

The association between anxiety disorders and religious involvement appears to be complex. In a comprehensive review of the relationship between religion and generalized anxiety in 7 clinical trials and 69 observational studies, Koenig and colleagues found that half of these studies demonstrated lower levels of anxiety among more religious people, 17 studies reported no association, 7 reported mixed results, and 10 suggested increased anxiety among the more religious [7]. This suggests the need for a more individualized approach in assessing the role of religion on a patient's anxiety symptoms.

A number of pathways have been discussed in the literature through which religion/spirituality may buffer against depressive and anxious symptomatology, including decreased substance use/abuse, increased support, and emphasis of positive emotions, such as altruism, gratitude, and forgiveness [15, 16]. In addition, religion generally promotes a positive worldview, answers some of the why questions, promotes meaning, can discourage maladaptive coping, and promotes

thinking outside oneself [16]. On the other hand, those who question their beliefs or tend to be more prone to guilt, scrupulosity, and following moral rules might show an increase in anxiety symptoms [17].

Mood Disorders

For individuals that find comfort in their religious belief system, rates of depression are often lower. As meta-analysis by Koening and colleagues showed in 93 observational studies, two-thirds found lower rates of depressive symptomatology and diagnoses in people who identified as more religious [7]. In 34 studies that did not find this inverse relationship, 30 found no association, and 4 reported that being religious was associated with more depression [7]. Additional longitudinal research suggests that greater self-reported religiousness predicts more mild symptoms of depression and faster remission at follow-up [7]. Smith and colleagues conducted a meta-analysis of 31 studies that provided spiritual and religious adaptations to group psychotherapies noting a medium effect size (d = 0.56) [18]. This meta-analysis concluded that spiritually oriented psychotherapy may be beneficial to individuals with primary diagnosis of depression, anxiety, and adjustment disorders [18].

However, religious beliefs and variables are not always related to better mental health outcomes. Some studies have found inverse relationships between depression and religious identification [7]. Factors such as denomination, race, sex, and types of religious coping may affect the relationship between religion or spirituality and depression. Negative religious coping (e.g., being angry with God, feeling let down), endorsing negative support from the religious community, and loss of faith correlate with higher depression scores [19]. In general, people of Jewish descent, Pentecostals, and those with no affiliation report higher rates of depression than other religious groups [20]. Higher rates of depression in people of Jewish descent, particularly those who are not actively religious, have been documented in both cross-sectional and longitudinal studies [20]. A variety of factors may explain why people of Jewish descent at least appear to be at higher risk, including that they may be more likely to report depressive symptoms and seek help from mental health professionals. Depression rates appear highest in Jewish people of Eastern European descent, and there has long been speculation that genetic factors may contribute to depression among Ashkenazi Jews [20]. Higher rates of depression in Pentecostals may be due to people with emotional problems self-selecting themselves into Pentecostal groups because of the latter's strong focus on overcoming emotional problems (e.g., many uplifting hymns, strong emphasis on socialization, and positive content of sermons) [20]. Another reason may be the emphasis placed on evangelism by Pentecostals, leading to drawing of members from lower socioeconomic groups that may be at higher risk for depression and other mental illnesses [21].

Depression is important to treat not just because of the emotional distress but also because of the increased risk of suicide. Since religious involvement is often

associated with less depression, less anger and hostility, lower rates of substance abuse, greater social support, and better coping with stress, it should not be surprising that religion is also related to less suicide [22]. Furthermore, most religions of the world condemn suicide. A systematic review of this literature, presented in the 2001 and 2012 editions of *Handbook of Religion and Health*, identified 141 studies that examined the relationship between religiosity and completed suicides, attempted suicides, or attitudes toward suicide [12]. Of those, 106 studies (75%) found an inverse relationship between the 2 factors, and only 4 studies (<3%) found more suicide attempts, completed suicide, or positive attitudes toward suicide among people with more religious or spiritual involvement [12].

Recommendations

The essential components for mental health practitioners considering religious issues in diagnosis and treatment are to:

1. Obtain information about patients' religious and cultural values.
2. Liaison with one or more well-informed people from the same cultural-religious background.
3. Consider whether religious functioning is problematic.
4. Consider whether religious functioning has been affected by other psychopathology.
5. Consider how religion is used in coping, with emphasis placed on contextual factors.
6. Help patients clarify how their religious beliefs and practices influence the course of illness. Refrain from giving religious advice. Whatever one's religious background, the professional's moral stance should be neutral, with no attempt to manipulate the patient's beliefs. Clinicians must be aware of how their own religious beliefs affect the therapy process. Direct religious intervention, such as the use of prayer, remains controversial.
7. Remain alert to the need for religious sensitivity and the need to become educated about specific beliefs and practices. At times, patients' religious views may conflict with medical/psychotherapeutic treatment, and clinicians must endeavor to understand the patient's worldview and, if necessary, consult with clergy or religious leaders. It may be appropriate to involve members of the religious community to provide support and to facilitate rehabilitation.
8. Religion or spirituality may have therapeutic implications for mental health. Randomized-controlled trials indicate that religious interventions (e.g., spiritual meditation, pastoral services) among religious patients enhance recovery from anxiety, substance use, and mood symptoms [23]. Psychoeducational groups that focus on spirituality can lead to greater understanding of problems, feelings, and spiritual aspects of life [24].

Conclusion

In order to treat patients through a culturally competent lens, it is important to examine all aspects of their life, including religious and spiritual beliefs. This is an individualized and personal experience, so asking background questions, gaining insight into belief systems, and appreciating the role it plays in a patient's world are important. Mental illness is heavily influenced by a person's understanding of how they exist in the world and their relationship to the importance of human life. While religion can often provide comfort to those experiencing depression and be a protective factor against suicide, it can also cause internal turmoil to those who are concerned their actions are sinful or become a preoccupation or part of a delusion. Throughout history mental illness and religion were linked, including beliefs that mentally unwell were possessed by demons, displeased a higher power, or not on the virtuous path. Even now, religious problems may present with psychiatric disorders such as psychosis, OCD, and mania or independent of them. Treatment historically focused on religious healing. With the Western medicine movement, we now look to different methods of treatment, including pharmacological approaches. However, within the medical model, it is still crucial to address the religious undercurrent. It is often important for mental health professionals to consult religious leaders to gain further insight into protective or maladaptive aspects of religious beliefs and assess functioning and the context in which it presents. Even when a religious preoccupation presents as a psychiatric symptom, gaining insight into the importance and specific benefits may help with treatment planning and coping. It is important to assess adaptive functioning so that the clinician can understand when a client is using maladaptive coping skills. Obtaining history that determines religious involvement predating psychiatric symptoms can provide diagnostic clarification and provide a path toward treatment. Distinguishing whether religious focus is symptomatic or protective (or neither) is essential, but it is also important to remember that even when religiosity is attributed to psychopathology, it may be incorporated into treatment.

Summary of High-Yield Points

- Throughout human history, many cultures have viewed mental illness as a form of religious punishment or demonic possession.
- Although religious identification is increasing worldwide, it is declining in Western Europe and North America and is lower in psychiatrists than other types of physicians [2, 4].
- It is important to obtain a religious and spiritual history of each patient, including understanding how religion and spirituality fits into their life, if at all, where they gain support and strength, the cultural and community context of their environment, and identified resources and supports in the community.

- Mental health professionals may consider liaising with one or more well-informed people from the same cultural-religious background, or religious leaders, to better understand and support their patient.
- Religious themes are a symptom in many psychiatric disorders. For example, loss of faith is common in depression and PTSD, religious preoccupations or compulsions may be part of an anxiety disorder, and grandiose or delusional religious beliefs may be symptoms of bipolar or psychotic disorders [3].
- Overall, most studies have found religious and spiritual identification to be associated with positive mental health outcomes including lower rates of suicidal behaviors, substance abuse, and depression and greater social support, optimism, and meaning and purpose in life [5, 23].
- When distinguishing between pathological or nonpathological religious experiences consider adaptive functioning preceding and following the religious experience, determine whether symptoms are acute or chronic, maintain a level of openness to exploring spiritual experiences, compare idiosyncratic behavior and beliefs to normative practices in religious/spiritual community (e.g., speaking in tongues, hearing the voice of God), and recognize that psychopathology is often characterized by greater intensity, terror, and decompensation than genuine spiritual experiences.

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