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Religion and mental health: evidence for an association

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Summary

The relationship between religion and mental health has been debated for centuries. History shows that religious organizations were often the first to offer compassionate care to the mentally ill; however, for hundreds of years the religious establishment also persecuted the mentally ill. Nevertheless, the first form of psychiatric care in Western Europe and the US was known as 'moral treatment', in which religion played a significant role. The teachings of Freud and others during the early twentieth century concerning the neurotic influences of religion have had an enormous impact on the field, nullifying the quite favorable views toward religion held by nineteenth century psychiatrists. In this article, we review research that has found both negative and positive associations between religious involvement and mental health. We then examine the implications of this research for the clinical practice of psychiatry in the twenty-first century.

Introduction

Religious beliefs and practices are prevalent and important to people in many countries around the world. For example, Gallup polls indicate that 96% of persons living in the US believe in God, over 90% pray, 69% are church members, and 43% have attended church, synagogue, or temple within the past 7 days (Princeton Religion Research Center, 1996). Despite advances in education, communication, science and technology, religious involvement has done anything but diminish in the past 60 years since Freud's death. To the surprise of many, an index of leading religious indicators monitored by the Gallup organization reported that religious interest was higher in 1998 than at any other time in the past two decades (with the exception of 1984) (Princeton Religion Research Center, 1999). Gallup polls also indicate that the percentage of Americans who think religion is increasing in influence (48%) has been higher in recent years than at any time since 1957 (Princeton Religion Research Center, 1998). These demographic figures are difficult to explain in light of Freud's predictions concerning religion in 'Future of an Illusion' (1927):

> Our God, Logos [reason], will fulfill whichever of these wishes nature outside us allows, but will do it very gradually, only in the unforeseeable future, and for a new generation of man. He promises noncompensation for us, who suffer grievously from life. On the way to this distant goal your religious doctrines will have to be discarded, no matter whether the first attempts fail, or whether the first substitutes prove untenable. And you know why: in the long run nothing can withstand reason and experience, and the contradiction which religion offers to both is all too palpable. (Freud, 1927, p. 54)

Freud was not alone in his opinion about the relationship of religion to mental health. Psychologist Albert Ellis, president of the Rational-Emotive Therapy Institute in New York City and one of the founders of cognitive-behavioral psychotherapy, has argued that the less religious people are, the more emotionally healthy they will be (Ellis, 1980, 1988). Similarly, psychiatrist Wendell Watters suggests that religious beliefs may contribute to the development of low self-esteem, depression, and even schizophrenia (Watters, 1992). Psychoanalysis, while believed to be compatible with the religious beliefs of patients (Meng & Freud, 1963), was often in practice not. Discussing the technique of analysis in *Problems of Psychoanalytic Technique*, Fenichel (1941) noted: 'It has been said that religious people in analysis remain uninfluenced in their religious philosophies since analysis itself is supposed to be philosophically neutral. I consider this not to be correct. Repeatedly I have seen that with the analysis of the sexual anxieties and with maturing of the personality, the attachment to religion has ended' (p. 89).

In contrast, Carl Jung believed that religion helped to bring about emotional stability and resolution of mental conflict. In his 1933 book, *Modern Man in Search of Soul*, Jung wrote:

> During the past thirty years, people from all the civilized countries of the earth have consulted me.

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> I have treated many hundreds of patients, the larger number being Protestants, a smaller number Jews, and not more than five or six believing Catholics. Among all my patients in the second half of life—that is to say, over 35—there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost that which the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook. (p. 229)

Thus, we have mental health professionals taking diametrically opposite positions on the benefits and liabilities of religious faith. Before we systematically examine research on the religion–mental health relationship, let us briefly digress to explore further the historical background on which the tension between religion and mental health rests.

Historical background

In Western civilization, some of the first and best care provided to the mentally ill in the general population was by religious organizations. For example, prior to the Christian era in Western Europe, according to the writings of Cicero and Plutarch, the mentally ill were often kept in dark cells and dungeons. One of the first hospitals for the mentally ill was established by religious orders in Jerusalem in AD 490 (Alexander & Selesnick, 1966). In the sixth century, the mentally ill were cared for in monasteries operated by the church, and by the twelfth century, the mentally ill in certain areas of Europe were even brought into religious people's homes and included in family life (Braceland & Stock, 1963). The first hospitals designed specifically to care for persons with mental illness, however, were not established until the early 1400s in Spain. These church-sponsored asylums, under the guidance of priests, gave better care to the insane than did State-supported hospitals as late as the sixteenth and seventeenth centuries.

In fact, toward the end of the Middle Ages, religious scientists suggested that biological mechanisms were responsible for mental illness. Around AD 1230, a Franciscan monk named Bartholomaeus wrote the *Encyclopedia of Bartholomaeus* in which he described mental illnesses as having natural rather than supernatural causes. Bartholomaeus localized the cause of insanity to the regions of the brain around the lateral ventricles (Kroll, 1973). Likewise, theologian Thomas Aquinas (AD 1225–1274) made an attempt to synthesize religious beliefs and Aristotelian philosophy, work which became widely accepted among medieval scientists by the middle of the fourteenth century. Aquinas emphasized in his writings the interpretation of dreams and workings of the unconscious—centuries before Freud (Kroll, 1973).

The care provided the mentally ill by the church, however, was not always compassionate. The Renaissance Period in Western Europe ushered in an obsession with demonology. In 1487, *Malleus Maleficarum* was published, providing details on the diagnosis and treatment of demonic possession. If a subject (often a mentally ill person) could not be readily treated with exorcism, religious authorities might execute him or her by burning or decapitation. Over the next 200 years, according to Zilboorg (1941), thousands of people were put to death, and as late as 1692 in America, nearly 100 were accused and 19 executed at the Salem witch trials.

Reformers in the church, however, eventually brought an end to these persecutions. William Tuke, a devout Quaker, established the York Retreat in England in the early 1800s. Tuke believed that a purely medical approach to mental illness would ultimately fail to produce cures, since insanity was a disruption of the mind and the spirit. He discouraged the use of frequent bleedings, purgings, and ice baths (the medical treatments of the day), and instead encouraged exercise, work, and recreation, treating the mentally ill much like normal adults. Tuke's results from utilizing *moral treatment* (as it was called) were nothing short of amazing for the day. About the same time, Philippe Pinel developed a form of *moral treatment* based on egalitarian and humanistic principles of the Enlightenment (rather than Quaker philosophy) that quickly spread throughout Europe.

It was not long before moral treatment came to America. The Quakers, inspired by Tuke, brought moral treatment principles to New England leading to the development of hospitals such as the Hartford Retreat, modeled on the institution in York. Friends' Asylum in Philadelphia, established by Quakers in 1817, became the second mental hospital in the US.

According to Taubes (1998), moral treatment was the first established form of psychiatric care in the US. In America, moral treatment involved '… occupational therapy and amusements designed to distract patients from their irrational and unhealthy preoccupation, a structured agricultural life built around Christian virtues of self discipline and work, and a kind and respectful approach to patients, inspired by Protestant ethics' (Taubes, 1998, p. 1002). Many of the superintendents of America's early mental institutions were religiously devout (a number were Quakers and the rest were members of other Protestant denominations). Chaplains were routinely hired to live on the asylum grounds, providing patients with an opportunity to attend religious services (Taubes, 1998).

In fact, being allowed to attend services was a reward granted to patients for good behavior. According to Samuel Woodward (1842), 'By our whole moral treatment, as well as by our religious services, we try to inculcate all of that which is rational' (p. 41). In 1844, Woodward would begin the Association of Medical Superintendents of American

Institutions for the Insane (to become the American Psychiatric Association) and co-edit the association's official publication, the *American Journal of Insanity* (to become the *American Journal of Psychiatry)*. Amariah Brigham (1841), superintendent of the Hartford Retreat and co-editor of the *American Journal of Insanity* with Woodward, likewise indicated his feelings unambiguously in having '… no doubt that these services are beneficial to our patients. Permission to attend them is solicited by nearly all, and many are induced to exercise their self-control in order to enjoy this privilege' (p. 24).

These positive attitudes toward religion over the next 50–100 years, however, were to gradually reverse, stirred on by the spectacular scientific advances of the late 1800s and the articulate and convincing arguments by Sigmund Freud and others. The latter, however, formed their opinions largely based on negative personal experiences with religion (Meissner, 1984; Zilboorg, 1958) and experiences with the religion manifested by psychiatric patients. Systematic research did not enter the picture until the mid-twentieth century, and by that time, attitudes toward religion in the mental health professions had hardened.

Research on religion and mental health

In fact, research in the early 1950s and 1960s seemed to confirm the clinical experience of Freud, Ellis, and others. A major review of the literature published in the *American Journal of Psychiatry* in 1969 by Victor Sanua concluded that, 'The contention that religion as an institution has been instrumental in fostering general well-being, creativity, honesty, liberalism, and other qualities is not supported by empirical data. Both Scott (55) and Godin (22) point out that *there are no scientific studies* [italics added] which show that religion is capable of serving mental health' (p. 1203). Studies during this period, however, involved either convenience samples of college students (those most accessible to university professors) or psychiatric patients (those most accessible to mental health professionals). Studies of large random or systematic samples of mature, mentally stable adults would not come until later.

In the late 1980s and early 1990s, we began a series of studies looking at the relationship between religious involvement and mental health in mature adults either living in the community or hospitalized with medical illness. Our findings were quite different from those reported earlier in college students and psychiatric samples. First, we systematically asked medically ill patients how they coped with the stress of their medical illness. To our surprise, many of these patients reported that religious beliefs and practices were essential in this regard. In a study of 372 consecutive medical patients admitted to Duke University Medical Center, subjects were asked what they thought was the most important factor that enabled them to cope with stress (Koenig, 1998a). While no mention of religion was made by the interviewers when asking this question, almost one-half (42%) of patients surveyed promptly explained that it was their religious faith that helped them the most. When interviewers asked a more direct question about how much religion was used to cope with stress, nearly 90% of patients indicated 'at least a moderate extent' or more.

These figures would undoubtedly vary in different parts of the world. In the US, however, the finding is relatively common. According to Gallup surveys, the percent of Americans who indicate comfort or support from religion is 83% in the southern and mid-western parts of the US, compared to a still substantial 72% in the east and 70% in the west (Princeton Religion Research Center, 1982). From these data we conclude that religion is a widely prevalent means for Americans to cope with stress, particularly when stress is severe or out of control.

Again, this is not true in all areas of the world. For example, in certain parts of northern Europe religion is seldom used as a way of coping with stress, probably reflecting low rates of religious involvement in these countries. One study found that nearly 80% of persons in Sweden indicated 'none' for their degree of religiosity (Rudestam, 1972), compared to about 10% in the US. In a survey of 148 healthy adults from Sweden, Cederblad *et al.* (1995) found that only 1% used religion as a way of coping with stress. Likewise, in a sample of cancer patients from Norway, Ringdal *et al.* (1995) reported that 43% did not believe in God and 45% received no comfort from religion.

More interesting than the percentage of people indicating they use religion to cope, is whether religious persons actually cope better than the non-religious. We now turn to studies that attempt to objectively examine the relationship between religious involvement and a variety of mental health outcomes.

We recently completed a systematic review of research on religion, mental health, social support and substance abuse (Koenig *et al.*, 2001). This review attempted to uncover all research (regardless of findings) during the past century that examined the relationship between a religious variable and some indicator of mental health. This review utilized multiple on-line data bases (Medline, PsycLit, SocLit, etc.), and previously published and unpublished reviews of the literature. By retrieving articles and examining their reference lists until no more articles could be found on the religion–mental health relationship, we identified 850 studies. Each study is reviewed in detail in the original source (Koenig *et al.*, 2001); because of space limitations, we will summarize here the findings for a limited number of mental health outcomes and refer only to the most important studies. First we examined

relationships between religion and indicators of positive mental health (psychological well-being, hope and optimism, purpose and meaning in life); second, we examined associations between religion and emotional disorder (depression, suicide, anxiety); third, we assessed associations with social support; and fourth, we reviewed research on religion and substance abuse.

Negative associations with mental health

A number of studies in the 1950s and 1960s, as well as some recent studies, report an association between religion and worse mental health. In 1952, Dreger reported that religious college students were more conforming, dependent, and ego defensive than non-religious students. In 1954, Cowen reported a negative relationship between orthodox religious beliefs and self-esteem. In 1959 at De Paul University, Wright found that freshman male students with more liberal religious attitudes and less certain about religion tended to be better adjusted. In students at Wayne State University, Bateman & Jensen (1958) found that those with more religious training were more likely to turn anger in on themselves rather than express it outwardly.

Studying college students in Michigan and New York, Rokeach (1960) found that non-believers were less anxious than religious students, who complained more of working under tension, sleeping fitfully, and being distressed. Similarly, Dunn (1965) found that religious persons were more perfectionistic, insecure, depressed, and worried, with men having somewhat feminine interests and women having somewhat masculine interests. Among more recent studies, Schafer (1997) cross-sectionally surveyed 282 sociology students at California State University at Chico, examining the relationship between religious involvement and level of psychological distress. Importance of religion was positively related to greater distress, and those who indicated that their belief in God was 'uncertain' had the lowest level of distress.

Sorenson *et al*. (1995) surveyed 261 teenage mothers (228 unmarried) in south-west Ontario, following them before and after delivery. Depressive symptoms were assessed along with religious affiliation, church attendance, and self-rated religiousness. Catholics, those from other conservative religious groups, and mothers who attended religious services more frequently had higher depression scores. The highest scores were found among girls who co-habitated with someone while continuing to attend religious services. The investigators concluded that religion may foster feelings of guilt or shame, erode feelings of competence, self-worth, and hopefulness, and encourage withdrawal of community support from those who do not conform to social norms.

Studies in adults reporting an inverse association between religion and mental health are much less common. Neeleman & Lewis (1994) cross-sectionally compared the religious beliefs and attitudes of psychiatric patients with those of orthopedic patients at hospitals in London. Psychotic schizophrenics and depressed patients were significantly more likely to report religious experiences compared to orthopedic patients (48% versus 38% versus 17%, respectively, $p=0.05$). These differences persisted after controlling for race, age, and other covariates ($p<0.005$).

Some research suggests that the effects of religion on mental health may differ depending on the type of stress being experienced. Strawbridge *et al.* (1998) cross-sectionally examined the relationship between depression and religious involvement in 2537 adults in California, finding that while religiosity buffered the effects of financial and health stressors, it was associated with greater distress in subjects facing family crises. Investigators concluded that religious resources may be more helpful for problems originating outside the individual (like poor health or financial problems) than for stressors perceived as resulting from personal failures (trouble with children or relatives). Of course, problems with children and relatives may also have brought about greater religious activity (e.g. prayer for troubled children).

There is little doubt that religion can be used to rationalize hatred or prejudice or be found among those with excessive dependency, obsessional thinking, perfectionism, exaggerated guilt, or excessive anxiety (Pruyser, 1977). Religious people may have high expectations of themselves and of others, and may exclude or judge those who believe or live differently than they do. Some religious people may be hypocritical, putting on an external show but actually using religion as a means to another end—social status, business success, or power and influence. We recognize these associations from clinical practice and common knowledge. In general, however, do religious beliefs and rituals lead to or cause mental disturbance, or does mental disturbance lead to greater religious activity? Furthermore, if religious beliefs and practices adversely affect mental health, do they also have positive effects that outweigh the negative?

Many studies reviewed above were older ones that failed to control for covariates, involved college students or adolescents without mature religious faith, involved samples of convenience, or employed cross-sectional designs that prevented determination of causality. As noted above, inverse cross-sectional relationships between religion and mental health may mean that being religious increases mental distress, or it may mean that mental distress increases religiousness as persons seek comfort and solace from these beliefs. The latter possibility should not be easily dismissed, given the common finding that people turn to religious activity like prayer to cope

during crisis (as we found earlier for people with serious medical problems). Let us now include the other side of the picture—research that finds a positive association between religion and mental health.

Positive associations with mental health

Well-being and life satisfaction

Although some studies—many of which are reviewed above—find lower well-being among the more religious, this finding is in the minority. Of 100 studies identified in the systematic review, 79 (nearly 80%) found religious beliefs and practices consistently related to greater life satisfaction, happiness, positive affect, and higher morale. Of 12 prospective cohort studies identified, 10 reported religiousness predicted greater well-being (Blazer & Palmore, 1976; Farakhan *et al.*, 1984; Graney, 1975; Kass *et al.*, 1991; Levin *et al.*, 1996; Maton, 1987; Musick, 1996; Ringdal *et al.*, 1995; Ringdal, 1996; Tix & Frazier, 1997; Willits & Crider, 1988). The magnitude of these associations often equaled or exceeded those between well-being and psychosocial variables like social support, marital status, or income.

Similar levels of positive association were found with hope, optimism, purpose and meaning. Of 14 studies examining these relationships, 12 reported significant positive associations and two found no association with religion. Not a single study found that religious persons had less hope or optimism than non-religious persons. Of the three studies using the best scientific methodology, all three found that those who were more religious had greater hope and optimism (Sethi & Seligman, 1993, 1994; Idler & Kasl, 1997; Ringdal *et al.*, 1995; Ringdal, 1996). Likewise, of studies examining the relationship between religious involvement and purpose or meaning in life, nearly all found significant positive associations (15 of 16 studies).

Affective disorder

We located 101 studies that examined the relationship between religion and depression, including 22 prospective cohort studies and eight clinical trials. Again the majority found lower depression among the more religious. Approximately two-thirds (60 of 93) of observational studies found lower rates of depressive disorder or fewer depressive symptoms in those who were more religious. Fifteen of the 22 prospective cohort studies found that greater religiousness predicted less depression. Of these, two studies identified depressed subjects and followed them over time, trying to identify characteristics at baseline that predicted resolution of depression 1 year later. Both studies found that depression resolved sooner among the more religious (Braam *et al.*, 1997; Koenig *et al.*, 1998). We also located eight clinical trials that examined the effects of a religious intervention on depression. Five of these studies found that depressed patients who received religious interventions recovered faster than subjects receiving either a secular intervention or no intervention (Azhar & Varma, 1995; Propst, 1980; Propst *et al.*, 1992; Toh & Tan, 1997; Razali *et al.*, 1998).

While some have claimed that religious persons exaggerate their well-being and mental health, denying emotional problems even when present (Ellis, 1987), it is more difficult to argue this point for an objective outcome such as suicide. We identified 68 studies that examined the relationship between suicide and religiousness, 84% (57) found lower rates of suicide or more negative attitudes toward suicide among the more religious.

With regard to anxiety, we found 76 studies that examined the relationship with religion: 69 cross-sectional or prospective cohort studies and seven clinical trials. Again, the majority of observational studies (35/69) found lower levels of anxiety or fear among the more religious. Of note, however, is that 10 studies found greater anxiety among the more religious. Two of these studies examined religious affiliation only (affiliated versus unaffiliated), three examined prayer or religious coping cross-sectionally (where anxiety may have led to greater religious activity), and the remaining studies were in HIV-positive gay males, patients with obsessive-compulsive disorder, sudden converts to religion, Muslims and Hindus in India, and college students. Perhaps more revealing is that four of five prospective cohort studies found that level of religiousness at baseline predicted less fear or lower anxiety over time (Cooley & Hutton, 1965; Morris, 1982; Paloutzian, 1981; Williams *et al.*, 1991), and six of seven clinical trials found that religious interventions reduced anxiety levels (Azhar *et al.*, 1994; Carlson *et al.*, 1988; Kabat-Zinn *et al.*, 1992; Miller *et al.*, 1995; Razali *et al.* 1998; Xiao *et al.*, 1998). These findings suggest that while anxiety may motivate religious activities, these activities may result over time in lower anxiety.

Substance abuse

The research is almost unanimous in reporting that religious persons are less likely to abuse alcohol or take illicit drugs. Again, we summarize here for space reasons. During our systematic review, we identified 86 studies that examined the religion–alcohol relationship (excluding studies that looked at denominational differences only). Of studies which measured level of religious involvement, 76 (88%) found lower alcohol use/abuse among the more religious. Of nine prospective cohort studies, eight found that greater religiousness at baseline predicted less alcohol use/abuse on follow-up. Of particular

significance was that over half of the 76 studies finding an inverse relationship between religion and alcohol use/abuse concerned an important at risk population—adolescents and young persons.

The results from studies of religion and drug use fit the same pattern as those for alcohol abuse. Of 52 studies that quantitatively examined the religion–illicit drug use relationship (excluding studies comparing denominations), 48 found significantly less drug use among the more religious. As with the alcohol studies, almost all reports finding less drug use among the more religious (42 of 48) again concerned adolescents or young adults. It is during these early years that the pattern of alcohol or drug abuse often begins, affecting the remainder of the person's life—hence the importance of identifying deterrents of use at this early stage.

Religion and social support

Much research over the past two decades has demonstrated the importance of social support in maintaining well-being, buffering stressful life events, preventing emotional disorder, and facilitating recovery, as well as promoting physical health (Myers, 1993; George, 1992; House *et al.*, 1988). If greater social support enhances mental health, and it can be shown that religious involvement enhances social support, then it would seem logical to suspect that religious involvement could similarly benefit mental health. In our systematic review, we located 20 studies that examined the relationship between religion and social support. Virtually all (19 of 20) found significant relationships between religious involvement and greater social support. A number of these studies surveyed random samples of thousands of subjects (Bradley, 1995; Ellison & George, 1994; Idler & Kasl, 1997; Koenig *et al.*, 1997; Ortega *et al.*, 1983).

Similarly, studies have shown that marital happiness and stability (a major source of social support for many) is greater among the more religious. In our systematic review, 35 of 38 studies found that greater religiousness or similarity in religious background predicted greater marital happiness or stability. Religious involvement appears to increase not only the amount of support, but also the quality of support and its impact on mental health (Cutler, 1976; Ortega *et al.*, 1983; Hatch, 1991; Ellison & George, 1994).

Explaining the association

How might greater religious involvement improve coping with stress, enhance well-being and quality of life, speed the resolution of emotional disorder, and reduce substance abuse? First and foremost, religious beliefs and practices promote an optimistic, positive world-view that gives experiences *meaning*. Meaning, in turn, provides a sense of purpose and direction that enhances hope and motivation. Consider the religious view of a forgiving, merciful, all-powerful God who is in control of life's circumstances and even the eternity that is beyond life, who is interested in people, engages them in his/her purposes, and responds to their pleas for help and assistance. This world-view sees the universe as personal and friendly, even designed for humans.

Compare this world-view with the perspective that sees events—whether triumphs or tragedies—as resulting from pure chance or luck, and sees the universe as impersonal, hostile and threatening to humans, who are rather insignificant beings in the grand scope of things. Whether the religious world-view is wishful thinking or not, cannot really be objectively evaluated. Nevertheless, the mental health consequences may be profound—particularly during times of severe stress, loss, or prolonged suffering—when finding meaning may be the key to survival (Frankl, 1959). Even Freud (1930) admitted that '… only religion can answer the question of the purpose of life. One can hardly be wrong in concluding that the idea of life having a purpose stands and falls with the religious system' (p. 25).

Second, most religious teachings prescribe support and care for one another. Promoting forgiveness, mercy, kindness, compassion, and generosity toward others enhances the bonding of persons within community and encourages a focus beyond the self. These outward-directed behaviors, in turn, may distract the person from their own problems and enhance well-being through seeing others benefited, thereby facilitating the resolution of their own emotional distress.

Third, religious beliefs and practices may enhance social support. As noted earlier, not only might family and marital bonds be strengthened, but support networks outside of family relationships are also likely to be expanded. The presence of supportive relationships at times of stress may then enhance coping and buffer against emotional disorder or substance abuse when painful losses occur.

As noted earlier, religion does not always promote positive emotions and supportive relationships. It may induce guilt, shame and fear. It can foster social isolation and low self-esteem in those not conforming to religious standards. Religion may restrict and impede personal growth and foster rigid, narrow thinking. For many patients who find their way to psychiatrists' offices, religion may be distorted or used maladaptively to defend against necessary personal change. Nevertheless, *on the balance*, it appears that religious beliefs and practices rooted within established religious traditions are generally associated with better mental health, higher social functioning, and fewer self-destructive tendencies.

Implications for psychiatric practice

The implications of the research for psychiatric practice are probably less clear than they are for medical practice, where guidelines for the assessment and appropriate use of religion as a therapeutic tool are now being worked out (Lo *et al.*, 1999; Post *et al.*, 2000). Nevertheless, studies show that spiritual needs are widely prevalent among psychiatric patients, a group to whom chaplains and clergy have traditionally had limited access. In some areas of the world, religious personnel are not allowed to see psychiatric patients unless the treating physician writes an order for it. Since the value of spiritual care is often not fully appreciated by mental health professionals, the religious and spiritual needs of psychiatric patients frequently go unmet. Surveying patients on the psychiatric inpatient service at Chicago's Rush-Presbyterian Medical Center, Fitchett *et al.* (1997) found that 88% had three or more current religious needs. Over three-quarters of these patients, however, had *not* spoken with a clergyperson during their hospital stay. Compare that figure to that for medical patients in the study, only 19% of whom had not spoken with clergy.

Role of the psychiatrist

There has been almost no research examining how psychiatrists can best address religious or spiritual issues in clinical practice. The following recommendations are based on our clinical experience and informal discussions with colleagues. While training guidelines now exist (Larson *et al.*, 1997), most psychiatrists have not received instruction on how to address religious or spiritual issues with patients and should therefore proceed cautiously.

An important first principle is that assessment, and especially interventions, should always be patient-centered. The psychiatrist must guard his or her own feelings about religion, whether positive or negative, so that these play as little role as possible in the process. Religion is a very personal issue for many patients, some of who may not wish to divulge this private aspect of their life to a psychiatrist, often fearful that the psychiatrist may not understand their beliefs. Other patients will welcome the addressing of religious issues, particularly after some trust has developed and where the psychiatrist has the same religious background as the patient. Cues should always be taken from the patient. This does not mean, however, that the psychiatrist should not attempt to address religious issues if the patient resists; in fact, examining the resistance may uncover a gold mine of psychological issues that require addressing before true healing can take place.

Assessment

It is becoming more accepted now that psychiatrists should take a brief religious history on all patients. This does not mean introducing, condoning, supporting, or discouraging religious beliefs, but rather inquiring about them to learn more about the patient's resources, underlying motivations and defenses. Examples of the type of information that might be gathered include the following:

- What is the patient's religious background?
  Knowing the religious background of the patient may help explain the patient's attitudes on a wide range of issues. For example, knowing that a patient is a devout Mormon, an evangelical Christian, orthodox Jew, a practicing Buddhist, or devout Hindu practitioner may have an enormous influence on choice of therapeutic approach (Koenig, 1998b).
- Are religious beliefs supportive and positive, or anxiety-provoking and punitive?
  Religious beliefs may be rigid, punitive, fear inducing, and isolating, or they may be supportive, uplifting, seeking to foster human traits such as forgiveness, mercy, kindness, and generosity. Knowing about the patient's beliefs can be very helpful, particularly about the specific beliefs concerning God (for monotheistic traditions). Is God seen as a distant creator, stern judge, mighty king, loving father, or as some other image, and why?
- What role did religion play in childhood, and how does the patient feel about that now?
  Was religious training emphasized during childhood? Was religion forced on the patient against his or her will, or was it encouraged and nourished, respectful of the patient's feelings? Does the patient look back fondly on their childhood religious experiences, or with regret?
- What role does religion play now in the patient's life and what purposes does it serve?
  Is religion important now to the patient, and how important is it? What purpose does religion play in the patient's life—a code of ethics to live by, an aid in raising children, a way of making friends, pleasing parents, etc.? Is the patient's religiousness or spirituality based primarily on a religious upbringing, or does it reflect attitudes of the patient's social group toward religion? Are attitudes toward religion the result of a carefully considered decision as an adult? If so, how did he or she come to that decision?
- Is religion used as a way of coping with stress, and how is it used?
  Are religious beliefs or practices used to bring comfort or solace in the face of life stress? Are the patient's personal religious beliefs important in this regard? How does the patient use personal religious beliefs or practices to relieve distress?
- Is the patient a member of a religious community and how supportive do they perceive that community to be?
  How involved is the patient in their religious community? What types of religious activities is

the patient involved in? Does he or she see the religious community as interested and supportive, as distant and uninvolved, or as condemning or judgmental?

- What is the patient's relationship with their clergy like?
  Does the patient know the clergy personally? Does the patient feel the clergy is interested and tuned in to the problems the patient is experiencing? Does the patient feel the clergy is knowledgeable and competent? Does the patient feel accepted and cared for by the clergy? As with the previous question, such information will help the psychiatrist assess the kinds and quality of religious support available to the patient. At times, the psychiatrist may wish to consult with the clergy, after obtaining the patient's consent of course.
- Are there any religious or spiritual issues that the patient would like to address in their therapy?
  Does the patient believe that religious or spiritual issues might be influencing their current emotional difficulties, symptoms or problems? How open is the patient to the psychiatrist addressing religious issues during therapy? If the patient is open, why is this so? If the patient is not open, why is this so?
- Might the patient's religious beliefs influence the type of therapy that he or she would be most receptive to and compliant with?
  Patients may feel reluctant to engage in psychotherapy for a variety of religious reasons. They may fear that the psychiatrist who uses psychoanalysis will not be supportive of their religious beliefs. The patient may only be comfortable with supportive, interpersonal, or cognitive-behavioral techniques. The need for psychotherapy may make the patient feel guilty because he or she believes it represents a lack of faith or lack of dependence on God. Furthermore, focusing on their own needs may be seen as selfish and self-centered, and in conflict with their beliefs. For example, a woman being helped to be more assertive about her needs and right to respect from a spouse may see these new behaviors as conflicting with religious beliefs concerning submission. These religious-cultural issues need to be considered as part of the therapeutic context.
- Does the patient's religious beliefs influence how he or she feels about taking medication?
  As with psychotherapy, religious patients may see the need for medication (or other biological treatments for mental illness) as a sign of spiritual weakness. If he or she just had more faith, perhaps medication would not be needed. Discontinuing medication may even be seen as a sign of faith—faith that one has been healed supernaturally. If the psychiatrist is unaware of such thinking, it may seriously interfere with compliance.

Coordinating religious resources

After determining the patient's religious background and spiritual needs, the psychiatrist may need to coordinate resources to meet those needs. This is particularly applicable to psychiatric inpatients, since the psychiatrist may control the patient's access to religious resources. This may involve requesting a visit from the hospital chaplain, the patient's minister, or religious friend from church, synagogue, mosque or temple. The patient may also wish to have access to inspirational programs on television, religious reading materials, or an opportunity to attend religious services.

Support patient's beliefs

Supporting religious or spiritual beliefs that the patient finds comforting may in some instances be helpful. This may be particularly true during periods of acute stress, if religious beliefs are healthy and emotionally supportive. During such crises, the psychiatrist seeks to support pre-existing defenses that have been used successfully in the past. According to Dewald (1971):

> One of the therapist's tasks in supportive treatment is to survey the various defenses available to the patient and determine which of these can most effectively be introduced, strengthened, encouraged or reinforced … He tries to help the patient more effectively used pre-existing defenses which for him are familiar, rather than introduce new ones the patient is not able to use himself. (p. 105)

By supporting healthy beliefs (for example, belief in God's love, understanding, mercy, forgiveness), the psychiatrist may be able to direct the patient away from unhealthy beliefs (fear of punishment or judgment) that may be contributing to the patient's emotional distress. When beliefs are unusual or bizarre, the psychiatrist must decide whether these are a result of psychosis or part of the patient's religious culture (which may be difficult to determine). If the patient's beliefs appear to be contributing to the psychiatric disturbance, then enrolling the patient's clergy for assistance may help to clarify beliefs or identify them as psychotic.

Participate in religious practices with the patient

In most circumstances, the psychiatrist's role is fulfilled by taking a religious or spiritual history, involving a chaplain or clergyperson when warranted, and supporting the healthy religious beliefs of the patient. If the psychiatrist has the same religious background as the patient and if the patient requests,

then there may be some rare circumstances in which the psychiatrist may engage in a religious activity with the patient. Admittedly, such instances should be chosen with great care.

The patient may be in acute distress and request prayer for comfort. In that situation, it is probably best that the psychiatrist encourage the patient to say the prayer while the psychiatrist participates silently. Remember the ancient adage, 'Cure sometimes, relieve often, comfort always.' The psychiatrist's presence during prayer will be viewed as supportive and comforting to the religious patient. Furthermore, much can be learned about the patient's emotional state, thought processes, and motivations during prayer.

However, conducting a religious intervention like prayer or giving spiritual advice to patients may also be a recipe for disaster. Spero (1981) notes that transference and counter-transference problems invariably arise when a religious therapist treats a religious patient, even when both have the same religious background. For example, the religious patient may have fantasies of a magical cure by the religious psychiatrist, or alternatively, may see the religious psychiatrist as punishing, demanding, or judgmental like a religious figure in the patient's past. The religious psychiatrist, futhermore, may experience counter-transference feelings toward the patient that range from rescue fantasies to neurotic projections leading to disdain or disgust for the patient. The psychiatrist's own religious beliefs may cause rejection or harsh treatment of patients who decide to continue in adulterous affairs, persist in abusing drugs or alcohol, or persist in a hedonistic life-style that conflicts with the religious principles of the psychiatrist. Thus, introducing religion into the clinical relationship must be done cautiously with full awareness of the attendant risks.

Prescribe religious belief or activity

If the research shows that religious interventions improve depression, relieve anxiety, or help patients recover from substance abuse, then it might be proposed that psychiatrists should prescribe religious beliefs or activities to patients who are not religious—just as therapists might seek to alter dysfunctional cognitions or encourage other healthy behavior patterns. Given the sensitive and personal nature of religious beliefs and practice, we feel that this is in most cases inappropriate and goes beyond the ethical boundaries of psychiatric practice.

Chaplain referral

The vast majority of psychiatrists will feel neither comfortable nor competent to address religious issues in depth. When need for specific spiritual counseling is present and this need goes beyond that which can be provided in the patient–psychiatrist relationship, referral to a sensitive, trained clergyperson is indicated. Present day chaplains, for example, receive vastly more training in meeting the emotional needs of patients than did their nineteenth century predecessors in the era of Woodward and Brigham. A certified chaplain in the Association of Professional Chaplains must typically graduate from a 4-year college, complete 3 years of divinity school, complete anywhere from 1 to 4 years of clinical pastoral education (CPE), and pass both written and oral examinations—not greatly different from the training a psychiatrist might go through before certification. In addition, some chaplains may receive special training to meet the needs of psychiatric patients. Pastoral counselors in the outpatient setting often have such training.

Summary and conclusions

The healing professions of psychiatry and religion have historically had a long and tumultuous relationship. The first mental hospitals were established and run by religious orders during the Middle Ages, although scientific advances in the understanding of mental illness tended to be suppressed during that time. During the Renaissance period, in fact, the mentally ill—thought to be possessed by demons—were often persecuted by misguided religious authorities.

Ultimately, religious reformers helped to stop such persecutions. Psychiatric care as it developed in Europe and the US in the mid-nineteenth century came to be known as 'moral treatment', which had substantial religious influences. This cooperation between religious and mental health professionals, however, largely ended with the teachings of Freud and others concerning the neurotic influences of religion. Although early research seemed to confirm the widespread clinical lore that religion impaired mental health, many more recent studies utilizing better methodologies within the past two decades appear to reveal quite the opposite, i.e. that religious involvement is generally associated with greater well-being, less depression and anxiety, greater social support, and less substance abuse.

This large body of research, however, is not well-known to many mental health professionals who were introduced to the harmfulness of religion during their psychiatric training and remain skeptical about the mental health benefits of religious practice. Some of this skepticism is fueled by valid concerns about the apparent ill effects of religion on mental health (which actually may be the aberrant or conflictual use of religion by those with mental illness). Most religions that have survived over time and developed

stable traditions tend to advocate a hopeful and optimistic world-view, encourage human traits like altruism, forgiveness, and kindness, promote the establishment and maintenance of social relationships, all of which may contribute to better mental health. The research presented in this chapter suggests that the twenty-first century may see a narrowing of the wide gulf that separated religion from psychiatry in our recent past.

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