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The Centre for Applied Research and Evaluation-International Foundation

Global Position Statement:

Religion and Spirituality in Mental Health Care

Introduction:

Careif is an international mental health charity that works towards protecting and promoting mental health and resilience, to eliminate inequalities and strengthen social justice. Our principles include working creatively with humility and dignity, and with balanced partnerships in order to ensure all cultures and societies play their part in our mission of protecting and promoting mental health and wellbeing. We do this by respecting the traditions of all world societies, whilst believing traditions can evolve, for even greater benefit to individuals and society.

Careif believes that knowledge should not only be available to those with wealth or those who live in urban and industrialised parts of the world. It considers knowledge sharing to be a basic human right, particularly where this knowledge can change lives and help realise true human potential. Furthermore, there is substantial knowledge to be found in low and middle income countries and within rural and poorer areas of the world and this knowledge is just as valuable to the wellbeing of people in areas which are wealthier. This Position Statement aims to highlight the current position and need for understanding the role of culture, spirituality and religion in the diagnosis and treatment of mental illness.

Globalisation has created culturally rich and diverse societies. During the past several decades, there has been a steadily increasing recognition of the importance of cultural influences on life and health. Societies are becoming multi-ethnic and poly-cultural in nature worldwide, where different groups enrich each others' lives with their unique culture.

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Cultural transition and acculturation is often discussed as relevant to migrants and the need to integrate, when in fact it is of relevance to all cultures in an ever-interconnected world. It is, indeed, necessary to be equipped with knowledge about cultures and their influence on mental health and illness.

Until the early 19th century, psychiatry and religion were closely connected. Religious institutions were responsible for the care of the mentally ill. A major change occurred when Charcot and his pupil Freud associated religion with hysteria and neurosis. This created a divide between religion and mental health care, which has continued until recently. Psychiatry has a long tradition of dismissing and attacking religious experience. Religion has often been seen by mental health professionals in Western societies as irrational, outdated, and dependency-forming and has been viewed to result in emotional instability.

The Evidence:

It has been suggested that religion and spirituality are analogous to sedimentary rock (Smith Jr, 2017) in as much as they are both binding and integrative - in the case of sedimentary rock, it is foundational and "gathers unto itself" many diverse layers while remaining strong and resistant; in the case of religion and spirituality, diverse individuals, cultures and communities are bound, through numinous experiences by ethical standards into a "moral community" which also withstands outside pressures - sometimes including mental health interpretations and interventions. Thus, the sciences of mental health often seem to be in conflict with religious beliefs. However, there are areas of antagonism in these two approaches to human sufferings, there are also several areas of complementarities (Harding, 2016) resulting in faith-based groups being recognised as being an important addition to health care interventions - although there are mental health professionals who continue to resist such collaboration (Leavey, Loewenthal and King, 2017)

> *"Whilst there appears to be agreement that religion and spirituality are not the same, and that the latter can mean different things, what those different things are seem more elusive. […] Spirituality is seen as something broader than religion, and entails a high degree of meaning, seeking a quest for harmony with the world".*
> *(Careif/WPA Wellbeing, 2016)*

By now several thousand studies have been conducted demonstrating positive associations between mental health, spirituality and religion. (Koenig, King and Carson, 2012). Those who are more religious generally manifest better indices of mental health. The vast majority of studies have been cross-sectional and have focused on religious attendance and beliefs among North American Christians. There has been far less work examining rituals, prayers and other aspects of being religious (Dein & Littlewood 2007; Dein 2010).

> *"It allows me to dream on the one hand and on the other to accept life as it is with all its limitations and disappointments. For example, I can dream about aspiring to my ambitions and know that if that is the right path then I can realise it with effort from myself and advice from others those who*

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know me. As the mother of a baby who died at 5 months as the result of sudden infant death, I can say that however grief stricken I was, and still am, I have the reassurance that she is with God and that I will see her again when Jesus calls me home". (Careif/WPA Wellbeing, 2016)

On balance, being religious results in more hope and optimism and life satisfaction (Koenig, 2009), less depression and faster remission of depression (Koenig, 2007, Smith, McCullough & Poll, 2003), lower rates of suicide (Van Praag, 2009), reduced prevalence of drug and alcohol abuse (Cook, Goddard & Westall, 1997) and reduced delinquency (Johnson, Larson & McCullough, 2000). Studies on anxiety demonstrate rather mixed results. Although some studies demonstrate reduced anxiety rates, others find that anxiety levels are heightened in the more religious (Koenig, King & Carson 2012, Shriev- Neiger & Edelstein 2004).

Work on schizophrenia is still at an early stage; recent studies in Switzerland suggest that religious individuals with psychotic illnesses deploy prayer and Bible reading to help them cope with their voices, and higher levels of religiosity may increase medication compliance (Mohr et al. 2006, Mohr et al. 2011).

"Throughout my life I have always been interested about my place in the world, my connection to other people and religion. I make a point of learning about all faiths by visiting their places of worship and try to use their good teachings to inform my life along with my own developed morals and principles". (Careif/WPA Wellbeing, 2016)

Although the predominant focus of the extant literature on religion and mental health is on Christianity, there has been fairly recent work on Islam (Abu- Rayyah & Khalil 2009), Judaism (Rosmarin et al. 2009) and Hinduism (Tarakeshwar, Pargament & Mahoney 2003) suggesting that those who are religious have higher levels of mental health benefits. One important finding is that religious beliefs impact differentially on mental health according to the faith group of subjects. Some forms of religion may impact negatively on mental health particularly those promoting guilt, dependency and even suicide.

"I do think that spirituality is an inherent part of our make-up, whether we acknowledge it or not; for me, my 'belief' is that planet Earth is one giant organism and we are but a part of that - but we're too proud (or blind) to see it - and if we muck up our environment, our whole system - mental, emotional, physical - is affected and out of balance". (Careif/WPA Wellbeing, 2016)

There have been a number of criticisms of the above findings (Sloan, Bagiella & Powell, 1999). First, selection biases may occur in recruiting subjects. Second, there is little work on the non-religious and their mental health associations, including atheism and agnosticism (Hwang, Hamer & Cragun, 2009). While some people are spiritual – connected to a higher power from which they derive meaning – they do not belong to or participate in institutionalised religion. The similarities and differences between religion and spirituality warrant further research. Third, we need to take account of cultural factors on levels of beliefs and practices (Milstein, Maniere & Yali, 2010). Finally, it is imperative that measurement scales are theologically sensitive (Dein, Cook & Koenig, 2012).

"So, religion offers social opportunities and/or a Eudaimonic sense of purpose, which will vary according to the individual's sense of personal agency. Other researchers have described the issue of purpose as 'social buffering' […] Clearly, this can have positive value in unifying social groups, or negative, in that is sets one religious belief against another". (Careif/WPA Wellbeing, 2016)

Rather than belief or attendance, some researchers underscore the role of religious coping following adverse life events. Pargament (2010) argues for two sorts of coping, positive religious coping and negative religious coping. Positive religious coping (e.g. benevolent religious appraisals, religious forgiveness, etc.) involves a secure relationship with God and is associated with improved mental health. In contrast, negative religious coping (e.g. reappraisals of God's powers, feeling abandoned or punished by God, etc.) reflects a tenuous relationship with God and is associated with worse mental wellbeing.

Religious experience has received comparatively less research attention than attendance, beliefs and coping. The focus has been on three areas: mysticism, conversion and religious hallucinations. Religious conversion has generally been associated with positive mental health experiences. There are phenomenological parallels between mystical and psychotic states although the outcomes are different (Brett, 2002). While mystical experiences usually positively impact on mental health, psychosis is generally a negative experience (Jackson & Fulford, 1997). There is some work on hearing God's voice among Pentecostal Christians in London suggesting that hearing God's voice is normative in some of this group and may facilitate coping (Dein & Littlewood, 2007).

"As I get older, I'm able to realise the importance of spirituality in my wellbeing, so have spent time trying to understand different religions and deeper spiritual beliefs to realise where I lie, or what lies in me, and have found meditation and Buddhist teachings to be beneficial to seeing the world in a way that feels right, and congruent, and therefore allows me to feel well… or be well, even when I don't feel it". (Careif/WPA Wellbeing, 2016)

Finally, research has focused on the incorporation of religious activities such as prayer, Bible reading and ritual into Cognitive Behavioural Therapy (CBT). Some evidence suggests that Christian-based CBT is more effective among Christian patients with depression and anxiety than traditional non-religious CBT. Future work in this area should concentrate on which therapies are efficacious for which patients and which therapists should be conducting them (Propst et al.1992, Smith, Bartz & Richards, 2007).

"The relationship between, religion wellbeing and happiness is commonly discussed, but here we have a chicken and egg situation: are happy people more likely to be religious, or does religion bring a sense of happiness?" (Careif/WPA Wellbeing, 2016)

Religion as an adjunct in the treatment of mental illness is one which the discipline of psychiatry must be very aware of and sensitive to. However, religion is not limited to worship of a particular deity but

may incorporate other day-to-day factors. For patients, their family, faith leaders, and community interveners, determining whether the problem faced by the individual is based on cultural beliefs or on Eurocentric comprehensions of mental illness can be quite difficult. In addition, persons with a colonial past often practise two or more variants of the same religion; a hybridisation of variants or, indeed, completely different religions from the dominant society. For example, it may be that although "mainstream" and "traditional" religious institutions may be using the same religious tome, congregants in the two streams interpret the "word" quite differently. (Leavey, Loewenthal & King, 2017)

Despite the findings described here and elsewhere in the literature, there is a religiosity gap between clinicians and their patients. Careif supports cooperation between mental health disciplines and religion and recognises such cooperation as one of the collaborative approaches to be pursued in providing appropriate mental health care which is sensitive to cultural differences. We would strongly advocate asking about religion in clinical practice - assessment, diagnosis and care, even though some have suggested that broaching religious issues in clinical work is a breach of boundaries (Poole & Higgo, 2011).

Careif calls for action:

A number of pathways have been discussed in the literature through which religion/spirituality influence depression/anxiety. These influences have been found to increase social support, lessen drug abuse and reinforce the importance of positive emotions, such as altruism, gratitude and forgiveness in the lives of those who are religious. In addition, religion generally promotes a positive worldview, answers some of the why questions, promotes meaning, can discourage maladaptive coping, and promotes other-directedness.

Careif strongly supports the incorporation of religion and spirituality into mental health care, thereby emphasising the bio-psycho-socio–spiritual model and acknowledging that religious and cultural ideology are deeply entangled with debates about the nature of equality, social cohesion, democracy, minorities, nationalism, security and foreign policy.

- All mental health professionals should be aware of the importance of religious and spiritual issues in mental illness and take seriously and treat respectfully the religious/spiritual views of their patients.

- Clinicians should learn to differentiate states of illness from normative religious experiences and be aware of their biases for or against religion and how these impact upon the therapeutic relationship.

- Mental health professionals should include spiritual history in their assessments and understand how to incorporate religious elements into treatments and care, seeking to respectfully understand the value to the patient.

- Mental health professionals should be aware of how culture and religion are interrelated and the meaning and relationship between culture and mental illness. They should also work closely with patients and those with lived experience to ensure understanding of the relationships and treat respectfully the religious/spiritual views of their patients.

- Clinicians need to work closely and collaborate with faith communities to develop mutual understandings of the relationships between religion and mental health.

Careif will pursue future work in this area; it will be with our international partners and other collaborators , taking account of the cultural factors in the provision of religiously based health care.

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