Research on Religion, Spirituality and Mental Health: A Review


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Abstract

Religious and spiritual factors are increasingly being examined in psychiatric research. Religious beliefs and practices have long been linked to hysteria, neurosis, and psychotic delusions. Recent studies, however, have identified another side of religion that may serve as a psychological and social resource for coping with stress. After defining the terms religion and spirituality, this paper reviews research on the relationship between religion, spirituality, and mental health, focusing on depression, suicide, anxiety, psychosis, and substance abuse. The results of an earlier systematic review are discussed and more recent studies in the United States, Canada, Europe, and other countries are described. While religious beliefs and practices can represent powerful sources of comfort, hope and meaning, they are often intricately entangled with neurotic and psychotic disorders, sometimes making it difficult to determine whether they are a resource or a liability.

Key words: religion, spirituality, depression, anxiety, psychosis, substance abuse

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Clinical implications
1. Religious beliefs and practices may be important resources for coping with illness
2. Religious beliefs may contribute to mental pathology in some cases
3. Psychiatrists should be aware of patients’ religious and spiritual beliefs and seek to understand what function they serve

Limitations
1. Review of recent studies is selective, not systematic
2. Studies without statistically significant findings are not discussed
3. Clinical applications are not addressed (left for Marilyn Baetz)
Despite spectacular advances in technology and science, 90% of the world’s population is involved today in some form of religious or spiritual practice. Non-religious persons make up less than 0.1% of the populations in many Middle-Eastern and African countries. Only 8 of 238 countries have populations where more than 25% say they are not religious, and those are countries where the state has placed limitations on religious freedom. Atheism is actually quite rare around the world. More than 30 countries report no atheists (0%) and in only 12 of 238 countries do atheists make up 5% or more of the population. In Canada, 12.5% are non-religious and 1.9% atheist.

Evidence for religion playing a role in human life dates back 500,000 years ago when ritual treatment of skulls in China took place during the Paleolithic period. Why has religion persisted over this vast span of human history? What “purpose” has it served and continues to serve? I will argue here that religion is a powerful coping behavior that enables people to make sense of suffering, provides control over the overwhelming forces of nature (both internal and external), and promotes social rules that facilitate communal living, cooperation, and mutual support.

Until recent times, religion and mental health care were closely aligned. Many of the first mental hospitals were located in monasteries and run by priests. With some exceptions, these religious institutions often treated patients with far more compassion than did state-run facilities prior to 19th century mental health reforms (reforms which were often led by religious persons such as Dorothea Dix and William Tuke). In fact, the first form of psychiatric care in the United States was “moral treatment,” which involved the compassionate and humane treatment of the mentally ill, a revolutionary notion at a time when mental patients were often put on display and/or housed in despicable
conditions in the back wards of hospitals or prisons. Religion was believed to have a positive, civilizing influence on these patients, who might be rewarded for good conduct by allowing them to attend chapel services.

In the late 19th century, however, the famous neurologist Jean Charcot and his star pupil, Sigmund Freud, began to associate religion with hysteria and neurosis. This created a deep divide that would separate religion from mental health care for the next century, as demonstrated by the writings of three generations of mental health professionals from Europe, the United States, and Canada.\(^5,6,7,8\)

Today, however, attitudes toward religion in psychiatry have begun to change. The American College of Graduate Medical Education now states in its \textit{Special Requirements for Residency Training for Psychiatry} that all programs must provide training on religious or spiritual factors that influence psychological development.\(^9\) Part of this change has been driven by scientific research over the past two decades that suggests religious influences need not always be pathological, but can actually represent resources for health and well-being.

\textbf{Definitions}

Before reviewing that research, however, religion and spirituality must be defined, since these terms have ambiguous meanings that may affect the interpretation of research findings. Religion is an expression whose definition is generally agreed on, and involves beliefs, practices, and rituals related to the ‘sacred.’ I define the \textit{sacred} as that which relates to the numinous (mystical, supernatural) or God, and in Eastern religious traditions, to Ultimate Truth or Reality. Religion may also involve beliefs about spirits,
angels, or demons. Religions usually have specific beliefs about the life after death and rules about conduct that guide life within a social group. Religion is often organized and practiced within a community, but it can also be practiced alone and in private. Central to its definition, however, is that religion is rooted in an established tradition that arises out of a group of people with common beliefs and practices concerning the sacred.

In contrast to religion, spirituality is more difficult to define. It is a more popular expression today than religion, since many view the latter as divisive and associated with war, conflict, and fanaticism. Spirituality is considered more personal, something individuals define for themselves that is largely free of the rules, regulations, and responsibilities associated with religion. In fact, there is a growing group of individuals categorized as “spiritual-but-not-religious” who deny any connection at all with religion and understand spirituality entirely in individualistic, secular terms. This contemporary use spirituality, however, is quite different from its original meaning.

According to Philip Sheldrake, professor of applied theology at the University of Durham, England, the origin of the word spiritual lies in the Latin term *spiritualis*, which is derived from the Greek word *pneumatikos* as it appears in Paul’s letters to the Romans and Corinthians. A spiritual person was considered someone with whom the “Spirit of God” dwelt, often referring to the clergy (p 3). In the Second Vatican Council, spirituality replaced terms such as ascetical theology and mystical theology. Although the Greeks used the word spiritual to distinguish humanity from non-rational creation, spiritual/spirituality has been distinctly religious throughout most of Western history. It was not until much later that Eastern religions adopted the term. Spiritual persons, then, were a subset of religious persons whose lives and lifestyles reflected the teachings of
their faith tradition. Spiritual people were those like Teresa of Avila, John of the Cross, Siddhārtha Gautama, Mother Teresa or Mahatma Ghandi.

The use of the term spirituality in health care has now expanded far beyond its original meaning. This expansion has resulted from attempts to be more inclusive in pluralistic health care settings in order to address the needs of both religious and non-religious persons. This degree of inclusiveness, while admirable in the clinic, makes it impossible to conduct research on spirituality and relate it to mental health, since there is no unique, distinct, agreed upon definition. Thus, researchers have struggled to come up with measures to assess spirituality.

When measured in research, spirituality is often either assessed in terms of religion, or in terms of positive psychological, social, or character states. For example, standard measures of spirituality today contain questions asking about meaning and purpose in life, connections with others, peacefulness, existential well-being, comfort and joy. This is problematic, since it assures that spirituality in such studies will be correlated with good mental health. In other words, spirituality – defined as good mental health and positive psychological or social traits – is found to correlate with good mental health. Such research is meaningless and tautological. To avoid this methodological problem, and maintain the purity and distinctiveness of the construct, I have proposed that spirituality be defined in terms of religion, where religion is a multi-dimensional construct not limited to institutional forms of religion. Thus, I will either refer to religion or use the terms religion and spirituality synonymously.
Religion as a Coping Behavior

Systematic research in many countries around the world finds that religious coping is widespread. With regard to the general population, research published in the *New England Journal of Medicine* found that 90% of Americans coped with the stress of September 11th by “turning to religion.” \(^{12}\) During the week following the attacks, 60% attended a religious or memorial service and Bible sales rose 27%. \(^{13}\) Even prior to the year 2000, more than 60 studies had documented high rates of religious coping in patients with an assortment of medical disorders ranging from arthritis to diabetes to cancer. \(^{14}\) One systematic survey of 330 hospitalized medical patients found that 90% reported they used religion to cope at least a moderate extent, and over 40% indicated that religion was the most important factor that kept them going. \(^{15}\)

Psychiatric patients also frequently use religion to cope. A survey of 406 patients with persistent mental illness at a Los Angeles County mental health facility found that more than 80% used religion to cope. \(^{16}\) In fact, the majority of patients spent as much as half of their total coping time in religious practices such as prayer. Researchers concluded that religion serves as a “pervasive and potentially effective method of coping for persons with mental illness, thus warranting its integration into psychiatric and psychological practice” \(^{\text{p 660}}\). In another study, conducted by the Center for Psychiatric Rehabilitation at Boston University, adults with severe mental illness were asked about the types of alternative health care practices they used. \(^{17}\) A total of 157 individuals with schizophrenia, bipolar disorder, or major depression responded to the survey. Persons with schizophrenia and major depression reported that the most common beneficial alternative health practice was religious/spiritual activity (over half reported
this); for those with bipolar disorder, only "meditation" surpassed religious/spiritual activity (54% vs. 41%).

Religious coping is likewise prevalent outside the U.S. A study of 79 psychiatric patients at Broken Hill Base Hospital in New South Wales, found that 79% rated spirituality as very important, 82% thought their therapist should be aware of their spiritual beliefs and needs, and 67% indicated that spirituality helped to cope with psychological pain. A survey of 52 patients with lung cancer in Ontario, Canada, asked about sources of emotional support. The most commonly reported support systems were family (79%) and religion (44%). Finally, a study of 292 outpatients with cancer seen at the Northwestern Ontario Regional Cancer Centre, Thunder Bay, found that among all coping strategies inquired about, prayer was used by the highest number (64%).

Why is religious coping so common among patients with medical and psychiatric illness? Religious beliefs provide a sense of meaning and purpose in difficult life circumstances that assist with psychological integration; they usually promote a positive world-view that is optimistic and hopeful; they provide role models in sacred writings that facilitate acceptance of suffering; they give people a sense of indirect control over circumstances, reducing the need for personal control; and they offer a community of support, both human and divine, to help reduce isolation and loneliness. Unlike many other coping resources, religion is available to anyone at any time, regardless of financial, social, physical or mental circumstances.

I will now briefly review studies examining the relationship between religion and mental health in five areas: depression, suicide, anxiety, psychotic disorders, and substance abuse. While some studies report no association between religious involvement
and mental health, and a handful of studies have reported negatives associations, the vast majority (476 of 724 quantitative studies prior to the year 2000 based on a systematic review), reported statistically significant positive associations.\textsuperscript{21} Because space is limited, I will briefly mention the results of that systematic review and then examine in more detail studies that exemplify research published more recently.

**Depression**

Prior to the year 2000, over 100 quantitative studies had examined the relationship between religion and depression.\textsuperscript{22} Of 93 observational studies, two thirds found significantly lower rates of depressive disorder or fewer depressive symptoms among the more religious. Of thirty-four studies that did not, only four found being religious was associated with significantly more depression. Of 22 longitudinal studies, 15 found that greater religiousness at baseline predicted fewer depression symptoms or faster remission of symptoms at follow up. Of eight randomized clinical trials, five found that religious-based psychological interventions resulted in faster symptom improvement than did secular-based therapy or controls. Supporting these findings was a more recent independently published meta-analysis of 147 studies that involved nearly 100,000 subjects.\textsuperscript{23} The average inverse correlation between religious involvement and depression was −0.10, which increased to −0.15 for studies in stressed populations. While this correlation appears small and weak, it is of the same magnitude as seen for gender (a widely recognized factor influencing the prevalence of depression).

Moreover, individual studies in stressed populations, particularly persons with serious medical illness, find a more substantial impact for religion on the prevalence and
course of depression. For example, 1000 depressed medical inpatients over age 50 with either congestive heart failure or chronic pulmonary disease were identified with depressive disorder using the Structured Clinical Interview for Depression.\textsuperscript{24} The religious characteristics of these patients were compared to those of 428 non-depressed patients. Depressed patients were significantly more likely to indicate no religious affiliation, more likely to indicate “spiritual but not religious,” less likely to pray or read scripture, and scored lower on intrinsic religiosity. These relationships remained robust after controlling for demographic, social and physical health factors. Among the depressed patients, severity of depressive symptoms was also inversely related to religious indicators.

Investigators followed 865 of these depressed patients for 12 to 24 weeks, examining factors influencing speed of remission from depression.\textsuperscript{25} The most religious patients (those who attended religious services at least weekly, prayed at least daily, read the Bible or other religious scriptures at least three times weekly, and scored high on intrinsic religiosity) remitted from depression over 50% faster than other patients (Hazard Ratio=1.53, 95% confidence intervals 1.20-1.94), controlling for multiple demographic, psychosocial, psychiatric, and physical health predictors of remission. Several other studies have likewise shown a positive impact for religion on course of depression.\textsuperscript{26,27,28}

With regard to psychiatric patients, however, there has been only one study on the course of depression. Bosworth and colleagues interviewed 104 elderly psychiatric inpatients, assessing public and private religious practices and religious coping.\textsuperscript{29} Depressive symptoms were assessed at baseline and 6 months later by a psychiatrist using the Montgomery-Asberg Depression Rating Scale (MADRS). Baseline positive
religious coping predicted significantly less depression on the MADRS at the six-month evaluation, an effect independent of social support measures, demographic, use of electro-convulsive therapy, and number of depressive episodes.

At least two studies (both cross-sectional) have examined relationships between religious involvement and depression in Canada, one reporting an inverse relationship and the other finding a positive relationship. O’Connor and Vallerand examined associations between religious motivation and personal adjustment in a sample of 176 elderly French-Canadians drawn from nursing homes in the greater Montreal area. Intrinsic religiosity was inversely related to depression and positively related to life satisfaction, self-esteem, and meaning in life. In the second study, Sorenson and colleagues followed 261 teenage mothers (87% unmarried) before delivery and 4 weeks after delivery in Southwest Ontario. They examined the relationship between religion and depressive symptoms during the first few weeks after babies were born. Catholics and teenagers affiliated with more conservative religious groups scored significantly higher on depression, and those who attended religious services more frequently also had higher depression scores. The highest depression scores, however, were among girls who cohabitated with someone while continuing to attend religious services.

Baetz and colleagues have shown in large cross-sectional community surveys of the Canadian population that religious attendance is associated with less depression and fewer psychiatric disorders. Participants indicating that spiritual values were important or perceived themselves as spiritual/religious, however, had higher levels of psychiatric symptoms. The researchers speculated that these individuals could have turned to spirituality/religion to reframe difficult life circumstances associated with
psychiatric illness. Bear in mind that the studies were conducted in largely healthy community-dwelling adults, with relatively low stress levels.

Two additional unpublished dissertations report studies of religion/spirituality and depression in Canadian men with prostate cancer and in bereaved caregivers of Canadians dying from AIDS. Both demonstrated positive effects for religious/spiritual involvement on post-traumatic growth and coping with illness. Supporting the findings of the Canadian caregiver study, Fenix and colleagues at Yale University recently followed caregivers of 175 recently deceased cancer patients for thirteen months, examining associations between religiousness and the development of major depressive disorder. Religious caregivers were significantly less likely to have developed major depressive order by the 13-month follow-up, a finding that persisted after adjusting for other risk factors. The same results have been reported for caregivers of patients with Alzheimer’s disease.

Thus, studies in medical patients, older adults with serious and disabling medical conditions, and their caregivers suggest that religious involvement is an important factor that enable such persons to cope with stressful health problems and life circumstances. This may not be true in all populations, however, as studies of pregnant unmarried teenagers and non-stressed community populations above suggest.

Critics say that most studies reporting positive results are observational and that some unmeasured characteristic may be related to both religion and depression, confounding the relationship. Genetic factors, in particular, have been implicated. In a fascinating study that examined the relationship of spirituality to brain serotonin (5-HT1A) receptor binding using positive emission tomography, investigators found that 5-
HT1_A receptor binding was lower in those who were more “spiritually accepting.” Note that lower 5-HT1_A receptor binding—the same pattern seen with spirituality—has been found in patients with anxiety and depressive disorders.\textsuperscript{39,40,41} Thus, rather than being genetically less prone to depression, religious/spiritually oriented persons may be at increased risk for mood disorders based on their serotonin receptor binding profile.

Suicide

In our systematic review of research conducted before the year 2000, 68 studies were identified that examined the religion-suicide relationship.\textsuperscript{42} Of those studies, 57 found fewer suicides or more negative attitudes toward suicide among the more religious, nine showed no relationship, and two reported mixed results. Seven of studies were conducted in Canada, and of those, five found fewer suicides or more negative attitudes toward suicide among the more religious, one found no association and one reported mixed results.

While recent research suggests that religion prevents suicide primarily through religious doctrines that prohibit suicide,\textsuperscript{43} there is also evidence that the comfort and meaning derived from religious belief may be relevant\textsuperscript{44} and may be especially important in persons with advanced medical illness.\textsuperscript{45} Religious involvement may also help to prevent suicide by surrounding the person at risk with a caring, supportive community.\textsuperscript{46}

Anxiety

One the one hand, religious teachings have the potential to induce guilt and fear that reduce quality of life or otherwise interfere with functioning. On the other hand, the
anxiety aroused by religious beliefs can prevent behaviors harmful to others and motivate pro-social behaviors. Religious beliefs and practices can also comfort those who are fearful or anxious, increase one’s sense of control, enhance feelings of security, and boost self-confidence (or confidence in Divine beings).

Prior to the year 2000, at least 76 studies had examined the relationship between religious involvement and anxiety. Sixty-nine studies were observational and seven were randomized clinical trials. Of the observational studies, 35 found significantly less anxiety or fear among the more religious, 24 found no association, and 10 reported greater anxiety. All 10 of the latter studies, however, were cross-sectional, and anxiety/fear is a strong motivator of religious activity. People pray more when they are scared or nervous and feel out of control (“There are no atheists in foxholes”). Cross-sectional studies, then, are less useful than longitudinal studies or randomized clinical trials. Of the seven clinical trials examining the effects of a religious intervention on subjects with anxiety (usually generalized anxiety disorder), six found that religious interventions in religious patients reduced anxiety levels more quickly than secular interventions or controls. Studies of Eastern spiritual techniques such as “mindfulness” meditation (from the Buddhist tradition) report similar effects, although their efficacy in anxiety disorders has recently been questioned.

More recent longitudinal studies add to this literature, and provide information on mechanisms. Wink and Scott followed 155 subjects for nearly 30 years from middle age into later life, studying the impact of religious belief and involvement on death anxiety. Analyses revealed no linear relationships between religiousness, fear of death, and fear of dying. Subjects with the lowest anxiety levels were those who were either high or low on
religiousness. Anxiety was highest among those who were only moderately religious, and in particular, those who affirmed belief in an afterlife but were not involved in any religious practices. Researchers concluded that it was the degree of religious involvement that was important in lessening death anxiety not simply belief in an afterlife.

Religious involvement may also interact with certain forms of psychotherapy to enhance response to therapy. Investigators at the University of Saskatchewan explored coping and motivation factors related to treatment response in 56 patients with panic disorder participating in a clinical trial. Subjects were treated with group cognitive-behavioral therapy, and then were followed up at 6 and 12 months after baseline evaluation. Self-rated importance of religion was a significant predictor of panic symptom improvement and lower perceived stress at the 12-month follow-up.

Just as positive forms of religious coping may reduce anxiety in highly stressful circumstances, negative forms of religious conflict may exacerbate it. For example, one recent study of 100 women with gynecological cancer found that women who felt that God was punishing them, had deserted them, or didn’t have the power to make a difference, or felt deserted by their faith community, had significantly higher anxiety. These results persisted after multiple statistical controls, and are consistent with other studies in medical patients.

**Psychotic Disorders**

Psychiatric patients with psychotic disorders may report bizarre religious delusions, some of which can be difficult to distinguish from normal religious or cultural
beliefs. Approximately 25-39% of psychotic patients with schizophrenia and 15-22% of those with bipolar disorder have religious delusions. Do religious beliefs play a role in the etiology of psychotic disorders or might they adversely affect the course of these disorders or response to treatment? Alternatively, might non-delusional religious beliefs and practices help these patients to cope with psychological and social stresses, thus serving to prevent exacerbations of illness?

Unfortunately, there are relatively few studies – particularly from the United States or Canada -- that have examined the relationship between religion and psychotic symptoms. In our earlier review of the literature, we identified 16 studies. Of the 10 cross-sectional studies, four found less psychosis or psychotic tendencies among those more religiously involved; three found no association; and two studies reported mixed results. The final study conducted in London, England, found religious beliefs and practices significantly more common among 52 depressed and 21 schizophrenic psychiatric inpatients compared to 26 orthopedic controls.

More recent research from Great Britain, Europe, the Middle East and Far East, helps to clarify these relationships. One of the largest and most detailed studies from Great Britain examined the prevalence of religious delusions among 193 inpatients with schizophrenia. Subjects with religious delusions (24%) had more severe symptoms, especially hallucinations and bizarre delusions, poorer functioning, longer duration of illness, and were on higher doses of anti-psychotic medication compared to patients with other kinds of delusions.

The content of religious delusions may be influenced by local religions or culture. A small study of four Chinese patients with schizophrenia in Hong Kong, China, reported
that religious content reflected Chinese beliefs involving Buddhist gods, Taoist gods, historical heroic gods and ancestor worship. In a larger and more systematic study in 126 Austrian and 108 Pakistani patients with schizophrenia, investigators found more grandiose, religious, and guilt delusions in Austrian patients (largely Christian) than in Pakistani patients (largely Muslim). In the largest study to date, investigators compared the delusions of 324 inpatients with schizophrenia in Japan with 101 patients in Austria and 150 in Germany. Again, religious themes of guilt/sin were more common among patients in Austria and Germany than in Japan, whereas delusions of reference such as "being slandered" were more prevalent because of the role shame plays in Japanese culture.

There is controversy about the impact that religious delusions have on the course of psychotic disorder. While some studies report that patients with schizophrenia and religious delusions have a worse long-term prognosis, others do not. In one of the most detailed studies to date, Siddle and colleagues did not find that patients with religious delusions (n=40) or patients who described themselves as religious (n=106) responded less well to 4 weeks of treatment than other patients. However, those with religious delusions had more severe illness and greater functional disability than other patients.

Longitudinal studies suggest that non-psychotic religious activity, in fact, may actually improve long-term prognosis in patients with psychotic disorders. In a prospective study of 210 patients with schizophrenia, Schofield and colleagues reported that regular church attendance was one of 13 factors associated with a good prognosis. In a second study that followed 128 hospitalized African-American patients with
schizophrenia for 12 months or until re-hospitalization, patients from urban areas were less likely to be re-hospitalized if their families encouraged religious worship during the hospital stay. Urban and rural patients were both less likely to be hospitalized if their families were Catholic, and were more likely to be hospitalized if they had no religious affiliation. A third study followed 386 outpatients with schizophrenia from clinics in Madras and Vellore, India, for two years, examining factors influencing course of illness. Patients who reported a decrease in religious activities at baseline had significantly worse outcomes. Finally, Swedish investigators followed 88 patients with adolescent-onset psychotic disorders for 10.6 years, during which 25% of patients attempted suicide. When anxiety and depressive symptoms were controlled for, only satisfaction with religious belief was a significant protective factor.

Most recently, Huguelot and colleagues from the University of Geneva, Switzerland, have published a series of papers on the religious beliefs and practices of 115 outpatients with schizophrenia and their interactions with clinicians. While a majority of patients reported that spirituality was important in their daily lives, only 39% had spoken about their spiritual concerns with clinicians. Many of these patients used religion to cope, with 71% reporting it instilled hope, purpose, and meaning in their lives (although 14% said it induced spiritual despair, lessened psychotic and other pathological symptoms in 54% (increased in 10%), increased social integration in 28% (worsened social integration in 3%), reduced suicide attempts in 33% (increased in 10%), reduced substance abuse in 14% (increased in 3%), and increased adherence to psychiatric treatment in 16% (decreased in 15%). Thus, overall, religion played more of a positive than a negative role in the lives and treatment of these patients.
Substance Abuse

Religious beliefs and practices provide guidelines for human behavior that reduce self-destructive tendencies and pathological forms of coping. This is particularly evident from research that has examined associations between religious involvement and substance abuse. As a form of social control, most mainstream religious traditions discourage the use and abuse of substances that adversely affects the body or mind. In our review of studies published prior to the year 2000, we identified 138 that had examined the religion-substance abuse relationship, 90% of which found significantly less substance use and abuse among the more religious.\(^7\)

The vast majority of these studies were conducted in high school or college students just starting to establish patterns of alcohol and drug use.

Since that review, the National Center on Addiction and Substance Abuse (CASA) at Columbia University reported the results of three national U.S. surveys: the 1998 National Household Survey, CASA’s National Survey of American Attitudes on Substance Abuse, and the General Social Survey.\(^7\) Adults who did not consider religion very important were 50% more likely to use alcohol and cigarettes, three times more likely to binge drink, four times more likely to use illicit drugs other than marijuana, and six times more likely to use marijuana, compared to adults who strongly believed that religion is important. The same pattern was seen for religious attendance, and an even more pronounced inverse relationship between religion and substance abuse was evident in teenagers. In addition, individuals who received both professional treatment and attended spirituality-based support programs (such as Alcoholics Anonymous or
Narcotics Anonymous) were far more likely to remain sober than if they received only professional treatment.

More recent studies support these findings, and emphasize their importance in younger persons and minority groups such as African-Americans, Hispanic Americans, and Native Americans -- those at high risk for alcohol and drug use disorders. For example, in a 3-year study of 732 Native Americans in four American Indian reservations in the upper Midwest U.S. and five Canadian First Nation reserves, Stone and colleagues found that traditional spiritual activities had a significantly positive effect on alcohol cessation.

While religious influences on substance abuse appear to be generally positive, this is not always the case. When persons from religious traditions that promote complete abstinence do start using alcohol or drugs, substance use can become quite severe and recalcitrant. Those individuals may completely withdraw from religious involvement, resulting in social isolation and worsening mental health due to feelings of guilt and shame. Furthermore, religious traditions that advocate complete abstinence from alcohol may deprive members of cardiovascular benefits of moderate, controlled drinking.

**Summary and Conclusions**

Many persons suffering from the pain of mental illness, emotional problems, or situational difficulties seek refuge in religion for comfort, hope, and meaning. While some are helped, not all such individuals are completely relieved of their mental distress or destructive behavioral tendencies. Thus it should not be surprising that psychiatrists
will often encounter patients who display unhealthy forms of religious/spiritual involvement. In other instances, especially in the emotionally vulnerable, religious beliefs and doctrines may reinforce neurotic tendencies, enhance fears or guilt, and restrict life rather than enhance it. In such cases, religious beliefs may be used in primitive and defensive ways to avoid making necessary life changes.

However, systematic research published in the mental health literature to date does not support the argument that religious involvement usually has adverse effects on mental health, but rather quite the opposite. In general, studies of subjects in different settings (medical, psychiatric, the general population), from different ethnic backgrounds (Caucasian, African-American, Hispanic, American Indian), in different age groups (young, middle-age, and elderly), and in different locations (U.S. and Canada, Europe, countries in the East), find that religious involvement is related to better coping with stress and less depression, suicide, anxiety, and substance abuse. While religious delusions may be common among those with psychotic disorders, healthy normative religious beliefs and practices appear to be stabilizing and may reduce the tremendous isolation, fear, and loss of control that those with psychosis experience. Clinicians need to be aware of the religious and spiritual activities of their patients, appreciate their value as a resource for healthy mental and social functioning, and recognize when those beliefs are distorted, limiting, and contribute to pathology rather than alleviate it.
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