Religion and Spirituality Can it Adversely Affect Mental Health Treatment?

Religion and spirituality unquestionably have a place in the treatment of many mental health patients. More than 700 studies have investigated the relationship of religion and mental health, with nearly 500 demonstrating a positive association between the two. Various investigations have shown religious involvement to be positively correlated with well-being, happiness, life satisfaction, hope, optimism, purpose and meaning in life, higher self-esteem, greater social support and less loneliness, lower rates of suicide and fewer positive attitudes toward suicide, less anxiety, less psychosis and fewer psychotic tendencies, lower rates of alcohol and drug use/abuse, less delinquency and criminal activity, and greater marital stability and satisfaction (Koenig, 2009; Koenig, Mc-Cullough, & Larson, 2001).

But are there instances when religion can actually interfere with care or worsen patient outcomes? Any modality of medical or psychological treatment, no matter how beneficial, can have adverse effects, and this is true for religion as well. Although we believe that the occurrence of adverse effects of religion on mental health are infrequent relative to the much larger number of positive benefits, there are circumstances that demonstrate how religion may negatively affect the treatment course of some mental health patients.

Some patients may develop feelings of excessive guilt and condemnation because of religion (Koenig, 2007). Parts of many religious writings describe God’s judgments for sin. Patients who focus on these writings may overlook the numerous scriptures that portray God’s forgiveness. Patients who do not feel they meet God’s standards may experience distress associated with striving to be virtuous (Exline, 2002).

Religion may cause or increase anxiety for certain individuals. For example, patients may worry about the welfare of family who do not share the same beliefs (Exline, 2002). Anxiety about judgment for sin, prophecies of future events, the rising of the Antichrist, and other issues may trouble some patients. Strong beliefs in the pervasiveness of sin have been positively linked with anxiety (El-lison, Burdette, & Hill, 2009).

Intense religious experience can lead to transient psychotic episodes. Psychotic breakdown linked to religious experience (sometimes referred to as the Jerusalem syndrome; Bar-El et al., 2000) or meditation (Kuijpers, van der Heijden, Tuinier, & Verhoeven, 2007) have been described. Fortunately, chronic mental illness usually does not result following these episodes (Linden, Harris, Whita-ker, & Healy, 2010).

Delusions in some psychiatric patients appear to be fueled by religious ideas. This is not to say that the delusions are caused by religion, but religion serves as the basis of their content. Delusions with religious content have been associated with poorer prognosis in schizophrenia (Mohr et al., 2010). Examples of this type of delusion include belief that one is Jesus Christ or possesses attributes of certain Biblical characters. Acting on the delusions may have serious or even fatal consequences (Reeves & Liberto, 2006). On the other hand, behavior related to religion such as reported contact with spirits or commands from God may be misdiagnosed as psychiatric disturbances; however, psychotic- or dissociative-like presentations are not necessarily symptoms of mental illness and may result from religious experience (Moreira-Almeida, 2009). Such phenomena could be considered normal in certain cultures and circumstances but abnormal in others.
Religion may cause problems with interpersonal relationships and diminish social support (Exline, 2002). Strain and even conflict may result from religious disagreements and from negative attitudes that may develop between the patient and others because of differing religious opinions. Decreased social support has a negative impact on mental health.

Sometimes patients may choose to rely solely on religion to address psychiatric issues, in essence substituting faith for treatment. In such cases, patients may demonstrate partial adherence, or treatment may be refused altogether. An example would be a patient with schizophrenia who abruptly stops taking antipsychotic medication because the patient believes he or she has been healed. Negative outcomes may result, particularly for those with serious psychiatric disorders. In some cases, patients may assume unrealistic expectations of their religion and adopt a sort of magical thinking that God will solve all their problems or even grant all their wishes (Koenig, 2007). Reality may be ignored, with patients making little attempt to use practical methods to address their psychological or social issues. In extreme cases, some individuals may unscrupulously use religion to manipulate and control certain psychologically vulnerable patients. The effect produced by this misuse of religion is not a part of medical treatment but occurs more often in the realm of cults.

Thus, religion may be seen to, at times, produce adverse effects in some mental health patients. Religion may be incorporated into mental health treatment in circumstances that are appropriate but should be avoided where it may worsen a patient’s status (Koenig, 2007). Clinicians should not involve religion in treatment of patients who do not desire it (Sloan et al., 2000). Provider-patient differences in beliefs are an area of concern because such differences could potentially create strained relationships, transference issues, and even alienation of the patient. However, we emphasize that events such as those noted above represent a miniscule proportion compared with the numerous benefits of religion shown in hundreds of studies.

Although mental health practitioners recognize that religion sometimes causes negative emotions that may lead to increased patient distress, they generally have a positive attitude toward the influence of religion and spirituality on health. Most (93%) of 1,144 physicians surveyed say that it is usually or always appropriate to inquire about the topic (Curlin et al., 2007). For patients who desire it as part of their treatment, and with whom the clinician has compatible beliefs, religion can be an invaluable adjunct to psychiatric care. We are confident that future research will continue to demonstrate the value of religion and spirituality for the treatment of mental health patients.

Clinicians may obtain more information about spirituality in clinical practice from Koenig’s (2007) *Spirituality in Patient Care: Why, How, When, and What*. This reference reviews various aspects of spirituality in medicine, including mental health, in a practical manner and discusses when and how spirituality may be incorporated into patient care if desired.

REFERENCES