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The relationship between schizophrenia and religion and its implications for care

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Summary

This paper focuses on the relationships between schizophrenia and religion, on the basis of a review of literature and the data of an ongoing study about religiousness and spiritual coping conducted among outpatients with chronic schizophrenia. Religion (including both spirituality and religiousness) is salient in the lives of many people suffering from schizophrenia. However, psychiatric research rarely addresses religious issues. Religious beliefs and religious delusions lie on a continuum and vary across cultures. In Switzerland for example, the belief in demons as the cause of mental health problems is a common phenomenon in Christians with high saliency of religiousness. Religion has an impact, not always positive, on the comorbidity of substance abuse and suicidal attempts in schizophrenia. In many patients' life stories, religion plays a central role in the processes of reconstructing a sense of self and recovery. However religion may become part of the problem as well as part of the recovery. Some patients are helped by their faith community, uplifted by spiritual activities, comforted and strengthened by their beliefs. Other patients are rejected by their faith community, burdened by spiritual activities, disappointed and demoralized by their beliefs. Religion is relevant for the treatment of people with schizophrenia in that it may help to reduce pathology, to enhance coping and to foster recovery. In the treatment of these patients, it appears useful to tolerate diversity, to respect others beliefs, to ban proselytism and to have a good knowledge of one's own spiritual identity.

Key words: schizophrenia; religion; spirituality; delusion; coping

Introduction

Schizophrenia is a chronic and debilitating disease, whose symptoms involve multiple psychological processes, such as perception (hallucinations), ideation, reality testing (delusions), thought processes (loose associations), feelings (flatness, inappropriate affect), behaviour (catatonia, disorganization), attention, concentration, motivation (avolition, impaired intention and planning) and judgment. These characteristics are associated with impairments in multiple domains of functioning (e.g. learning, self-care, working, interpersonal relationships and living skills), a comorbidity of substance abuse (33%), suicidal attempt (40%), and suicide (10%). This disorder is noted in great heterogeneity across individuals and variability within individuals over time. The onset of schizophrenia typically occurs during early adulthood [1].

The usual treatment of schizophrenia, based on the biopsychosocial model, involves the prescription of antipsychotic medications, psychological interventions, and familial and social support [2]. This model of schizophrenia doesn't take into account the religious dimension of the patient, in the sense of a broad definition of religion that includes both spirituality (concerned with the transcendent, addressing the ultimate questions about life's meaning) and religiousness (specific behavioural, social, doctrinal and denominational characteristics).

This paper addresses different areas pertaining to the relationship between religion, schizophrenia and psychiatric care. First, we will review the importance of spirituality and religious practices among people suffering from non-affective psychotic disorders and examine the reasons that may explain why religious issues were neglected in psychiatric research. We will also present the actual growing interest about the implications of religion and spirituality in the field of mental health. Then, the most studied religious issue in psychiatric research – religious delusions – will be discussed, while taking into account cultural factors in psychosis and considering the continuity between religious beliefs and religious delusions. The complex influence of spirituality and religious practices on substance abuse and suicidal attempts in schizophrenia will also be described, as well as the potential efficiency of spirituality and religious practices to cope with the illness. The question of

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the role of spirituality and religious practices in the process of recovery and reconstruction of the self as experienced by many patients will be debated. Finally, we will look at the implications of spirituality and religious practices for the care of people suffering from schizophrenia. The analysis of these aspects is drawn not only from literature on this topic, but also from an ongoing study about religiousness and spiritual coping we are conducting among outpatients suffering from chronic schizophrenia in the Department of psychiatry of the University Hospital of Geneva [3].

Religious practice among schizophrenic patients and research on this topic

A recent sociological study among the general population in Switzerland showed that 4% of people are atheists, 32% belong to Christian communities, 12% are members of other religious communities and 52% believe in a supernatural force without belonging to a religious community [4]. Spirituality and religious practices are salient in the lives of people suffering from non-affective psychotic disorders. For example, in a study that we conducted in the Department of psychiatry of Geneva [5], a third of the patients with schizophrenia were very highly involved during the first years of their illness in a religious community, and 10% of the whole sample were involved in minority religious movements. In our ongoing study conducted among schizophrenic outpatients, we also found that a third of them were highly involved in a religious community, and that another third gave a significant role in their life to spirituality, carrying out spiritual practices every day but without being involved in a religious community [3]. Other authors have also pointed out that religious practices were common among psychiatric patients in Europe [6, 7] and in North America [8, 9]. However, spiritual and religious dimensions have yet to be fully considered in psychiatric research. In a systematic review of four psychiatric journals between 1978 and 1982, only 2.5% of the articles included a measure of religion [10]. Even lower results were found for the period between 1991 and 1995: 1.2% of articles included a religious measure [11]. Moreover, the religious phenomenon was reduced to one question about denomination or religiosity in more than 80% of these studies. Several factors may be involved in the neglect of religious issues in psychiatric research: an underrepresentation of religiously inclined professionals in psychiatry that is noticeable among both North American [12] and British psychiatrists [13], a lack of education on religion or spirituality for mental health professionals [12, 14], and the tendency to pathologize the religious and spiritual dimensions of life by mental health professionals [14, 15]. The neglect of religious issues in psychiatry may also lie in the rivalry between medical and religious professions that comes from the fact that both professions deal with human suffering [16, 17]. As a patient of our current research said: "the physician is just like the person you go to for confession in the church, you can tell him anything you want, for me, this is what replaces religion today, this is why the church is loosing most of its members. A physician is like a religious counselor, even if he is not a believer, he really worries about you, and that has a spiritual side."

Nevertheless, in the last years, a growing body of literature has explored the implications of religion and spirituality in the field of mental health [18]. The World Health Organization considers spirituality, religion and personal beliefs as an important area in the evaluation of the quality of life [19]. Potential mechanisms that may link religiousness and spirituality to health outcome range from behavioural mechanisms (spirituality may be associated with a healthy lifestyle), social mechanisms (religious groups provide supportive communities for their members), psychological mechanisms (beliefs about God, ethics, human relationships, life and death) and physiological mechanisms (religious practices elicit a relaxation response). Multidimensional measurements tools, focused on the domains of religiousness and spirituality which could impact health, have been developed [20]. A practical tool, the HOPE questionnaire (H for sources of hope, strength, meaning, O for organized religion, P for personal spirituality and practices and E for effects on medical care), can be helpful for a formal spiritual assessment in a clinical interview [21].

The effects of religious beliefs on the psychopathology of schizophrenia

The study of religious delusions

Most studies have tried to assess how religious beliefs and religious practices influence psychotic illness. The study of religious delusions and hallucinations with religious content is of interest because these symptoms may lead to violent behaviour. Homicides have been perpetrated by patients who featured religious delusions [22]; religiously deluded people have taken statements literally in the Bible to pluck out offending eyes or cut off offending body parts [23, 24]; and antichrist delusions have led to violent behaviours [25]. In our

ongoing study, the suicidal attempts of two patients took place in a context of religious delusions: "One night, I was persecuted by voices, I drove a knife into my belly to kill the demons" (subject 66); "Once, during a crisis of anxiety, I was controlled by others, I believed myself to be in a relationship with God, I had to kill myself to save the children [playing in front of his house]. It was an obligation. I took a leash to hang myself, the leash broke, I fell down, the children were still alive, the anxiety went away" (subject 25). Religious delusions may also have an impact on the adherence to treatment. For example when some patients attribute psychotic symptoms to supernatural entities and refuse medication: "The psychiatrists say about me 'mental disorganization' … I find answers to my problems in the Bible … medication puts my thoughts in order … the question is to know to whom I will submit myself for the organization of my mind" (subject 1); "I hear voices who tell me to say 'God is great' and things like that, I have to pray, it is a cult that persecutes me, medication puts me to sleep and so hinders me from praying" (subject 12). Religious delusions have also been associated with a poorer outcome [26, 27]. This may be due to non-compliance but also to the clinical characteristics of those patients. At the level of non-content related characteristics of delusions (conviction, preoccupation, pervasiveness, negative affect, action), religious delusions are held with greater force than other types of delusions [28]. In a study of inpatients with schizophrenia, people with religious delusions were also more severely ill; they had more hallucinations for a longer period of time [29].

Prevalence of religious delusions

The prevalence of delusions and hallucinations with a religious content varies between cultures and over time. Some studies compared the prevalence of religious delusions among different populations [30–32]. Studies performed on inpatients with schizophrenia in Europe and compared to others countries showed a rate of 21% of religious delusions in Germany versus 7% in Japan [33] and 21% in Austria versus 6% in Pakistan [34]. A rate of 36% of religious delusions was observed among inpatients with schizophrenia in the USA [28]. These studies show the role of culture in interpreting the experience of psychosis. For example, in the case of paranoid delusion, the persecutors were more often supernatural beings among Christians than among Muslims and Buddhists. In Egypt, the fluctuations in the frequency of religious delusions over a period of 20 years have been linked to changing patterns of religious emphasis in this country [35]. Religious practices have been associated with a higher rate of religious delusions [29, 36, 37], but religiosity is not necessary for the development of religious delusions [29]. All these studies show the importance of culture on the content of delusions. Typically, the religious delusion themes are persecutory (often by the devil or demons), grandiose (believing to be God, Jesus or an angel) or related to belittlement (unpardonable sins) [38].

Continuum from religious beliefs to religious delusions

The definition of a religious delusion may affect the prevalence of religious delusions in different populations. Within a cross-cultural framework, anthropology points out that the "non-physical dimension" or "spiritual dimension" of human beings is a reality for most people throughout the world, and our own beliefs about the nature of physical existence affect the evaluation and the treatment of patients with mental disorders [39]. The evaluation of psychiatric patients is complicated by the fact that delusions are placed on a continuum with normality [36, 40, 41]. In the revision of the DSM-IV [42], a diagnostic category was created, "religious or spiritual problem", in order to take into consideration cultural issues in this classification system [43]. Religious delusions may be differentiated from religious beliefs on the basis of three criteria: 1) the patient's self-description of the experience is recognizable as a form of delusion, 2) other recognizable symptoms of mental illness are present in other areas of the individual's life (i.e. delusions, hallucinations, mood or thought disorder) and 3) the lifestyle, behaviour and direction of the personal goals of the individual after the event or after the religious experience are consistent with the history of a mental disorder rather than with a personally enriching life experience [44]. Another way to consider the continuum between religious beliefs and psychosis is through the theory of altered states of consciousness. Psychotic and spiritual experiences would be characterized by a qualitatively different type of consciousness – a transliminal state – as compared to an ordinary experience. The difference lies in the capacity of the subject to turn back to reality after the mystical experience, which doesn't occur in psychosis [45]. A cognitive model for the development of religious delusions based on the attribution theory has been outlined: religious people demonstrate an attributional style typically different from non-religious people. The external attributional style of religious people may lead them to ascribe psychotic experiences to external causes. This framework provides a buffer against stress which may help them to deal with negative life events [29]. While anthropological literature describes traditional beliefs within a culture, the western medical model emphasizes pathology, viewing a belief in demons as a religious delusion. Demonic attributions have been found in all diagnostic categories, not only in delusional disorders. Thus, these attributions cannot be regarded as mere delusions. Rather, they form a part of complex causal attributions of mental illness that must be interpreted against the background of cultural and religious factors [46].

It is easier to foster sensibility to cultural dif-

ferences when confronted with people from different backgrounds than ours [47–50]. In Switzerland, 7% of the people belong to protestant subcultures and present a high salience of religiousness [4]. Among them, the belief that demons are the cause of mental health problems is a common phenomenon: 82% of highly religious patients suffering from psychotic disorders said they believed in the influence of evil spirits and two-thirds of them sought help through ritual prayers for deliverance or exorcism. Many patients subjectively experienced the rituals as positive, allowed other explanatory models, consulted a physician and took medication without problems, but without an improvement in the outcome of psychiatric symptoms. Negative outcome (such as psychotic relapse) was associated with the exclusion of medical treatment and coercive forms of exorcism [51], as some religious healing systems exclude conventional medicine [52]. A psychiatrist working mainly in developing countries reached the same conclusions about the outcomes of deliverance rituals [38]. Thus, it seems that magical explanations for psychopathology do not automatically lead to non-compliance with psychiatric treatment, being rather a part of the "help-seeking pathways" of religious patients [53]. In a case study, neuroleptics relieved symptoms after exorcisms by Hindu, Muslim and Christian priests [54]. For example, three of our patients said: "I believed I was possessed by demons, I'd go to an exorcist priest, he taught me the gospel and he cast out the demons, he encouraged me to go to the psychiatrist. Now I believe half is schizophrenia, half is demonic possession, so I go on with the priest and I take half of my medication" (subject 25); "I don't know if what I see are the spirits of the dead or if I am crazy, so I have to learn more about spiritualism and go on with psychiatric treatment" (subject 32); "I don't know why I suffer from deep anxiety and hallucinations, the psychiatrist told me it was nerves, and the pastor and the members of my church pray for me to be delivered from bad things in the name of Jesus … it is God who gives wisdom to psychiatrists for medication, I pray for caregivers, I put my hope in God and I take my medication" (subject 81).

Finally, religious experience is brain-based, like every human experience. With the development of neuroscience, scientists are able now to explore the neural basis of spirituality and feelings [55]. Among some results, such studies have shown that the temporolimbic system is a substrate of religious-numinous experience [55]; the right temporal lobe is activated during mystical states [57], versus the left temporal lobe in religious delusion [58]; the serotonin system may serve as a biological basis for spiritual experiences [59]; the relatives of schizophrenic patients feature a greater risk for mental illness, but they also show a tendency for an increased creativity, more numerous achievements in many fields, as well as an intense interest in religion [60].

Impact of spirituality and religious practices on the comorbidity of substance abuse and suicidal attempts in schizophrenia

In the precedent section, we detailed some links between religion and the psychopathology of schizophrenia. Religion may also exert a protective factor against problematic behaviours among people with schizophrenia. Most religions disapprove or forbid toxic substance abuse and dependence [61, 62]. This protective role of religion has been observed for the comorbidity of alcohol dependence among depressive inpatients [63]. Comorbidity of drug abuse and dependence occurs in about one out of three people with schizophrenia. No studies have examined the influence of religion on this comorbidity, although religion may play this protective role: "God delivered me from smoking" (subject 68). On the other hand, drug dependence may hinder patients from belonging to religious communities: "I went to the spirit center for 10 years, I had all my friends there. Once I smoked hashish and I went there drunk. They were amazed, and I couldn't go again because they forbid drinking and smoking … I don't know what I believe in anymore, I don't know who is right, the spirits, the Buddhists, the Christians, I am spiritually lost" (subject 70).

Religious commitment has also been associated with lower rates of suicidal attempts and suicidal deaths [64]. Unfortunately, religious issues have been neglected with regards to suicidality [65] in psychiatric research, even if a few studies have been conducted with schizophrenic patients. In this population, a high suicidal rate of 10% and a suicidal attempt rate of 40% are observed. In this context, religion is sometimes the only protective factor against suicide as reported by people suffering from schizophrenia [66]. Religious values may protect against suicide: "even in the lowest moments of my life, I forbid myself suicide because of my religious background" (subject 72). But this is not always the case: "I have had spiritual experiences, they make me feel unique, but when I see and hear the voice telling me 'kill yourself!' it doesn't help me, I have made numerous suicidal attempts" (subject 56); it may even lead to suicide: "I want to live the eternal life today, what do you think about being injected to rejoin God?" (Subject 18). Consequently, this complex relationship between religion and suicidal behavior in schizophrenia still remains to be elicited.

Spirituality, religion and coping with schizophrenia

Compared to secular methods of coping, religion and spirituality can offer an answer to the problems of human insufficiency [67]. Thus, it is not surprising that so many people suffering from mental illness use religion to cope. People with schizophrenia have the same spiritual needs as any other human being. The studies on religion and schizophrenia bear essentially on the acute phase of the illness; only a few studies examine patients in remitted states when this aspect can be ascertained. Even if their spirituality is distorted at certain times, this doesn't mean that their spiritual experience is always illegitimate or the product of distorted thinking [68]. In London, 61% of psychotic patients used religion among their strategies to cope and 30% of them increased their religious faith after the onset of their illness. Religious coping was associated with better insight and good compliance with medication [6]. In a comparison of strategies to cope with auditory hallucinations, Saudi patients were more likely to use methods associated with religion than British patients (43% vs. 3%) [69]. In North America, 80% of the patients used religion to cope with their symptoms and daily difficulties, but only 35% attended church services [70]. In the same trend, the religious needs of psychiatric inpatients were comparable to those of medical/surgical inpatients in North America, but their integration into a faith community was far less common [71]. Religious coping strategies also help families to care for their ill relatives [72].

Patients with schizophrenia are particularly sensitive to stress [2]. The role of religion in coping strategies for stressful life events has been studied in different populations. Through a meta-analysis, helpful, harmful and mixed forms of religious coping were outlined, but the value of religious coping in different life circumstances are still to be determined [67]. In our ongoing study, more than half of the outpatients use spirituality on a large scale to cope with schizophrenia [3]. In general, helpful forms of coping include spiritual support: "Jesus is my only shield, I ask Him to help me in my daily activities, I feel that I am not alone, He shows me the way" (subject 16); congregational and clergy support: "the Buddhist monk teaches me how to meditate, to distance myself from my hallucinations" (subject 25); benevolent religious reframing (attribution of negative events to the will of God or to a loving God): "God puts you to the test, He sends you something for your search for spirituality to win against illness … without spirituality, there is a terrible emptiness, and even anxieties, deep anxieties, if you search for spirituality, it is greater, it is important to base your life on spirituality" (subject 60). In general, harmful forms of coping can be related to some discontent with a congregation or with God "God cannot help me, He can't help anybody. At the beginning of my illness, I prayed a lot, now I don't pray anymore, religion is just a system, it is not useful" (subject 10); "I am angry with some members of my community because I have not found any help at the human level, they moralized without knowing what I felt deep inside me" (subject 68); negative religious reframing "my illness is a plan from the devil or perhaps a punishment for my sins" (subject 77); "I had psychotic relapses, I felt guilty, having done bad things. It is in relation with good and bad, it is there. If I read the Bible, it disrupts me, I believe I am evil, so I shouldn't read the Bible" (subject 74). Forms of religious coping with mixed implications are religious rituals [51] and styles of religious coping. Self-directing coping emphasizes the individual's personal responsibility and active role in problem solving: "I have strongly believed in God since my childhood … for my illness, my relatives and my medication help me" (subject 62); some patients may defer the responsibility of problem solving to God or a figure of God: "the physicians told me they cannot cure me, I hope for E.T to cure me" (subject 2); in a collaborative style, both God and the individual are responsible for problem solving: "Help yourself, and heaven will help you … To cope with the voices, I read the bible, it helps me to put a measure on the voices: logically, if you say to yourself that you have eternity in front of you, the voices are nothing in fact, because they won't be there all the time." (Subject 20).

Spirituality and religious practices in relation to experience and subjectivity in schizophrenia

Biological, social and psychological factors are considered together to account for the causes of schizophrenia, its nature and the effects of various treatments. However the integration of subjectivity and experience in psychiatric research is a crucial component to understand the great heterogeneity of outcome in schizophrenia. The life stories of patients suggest that a central feature of the improvement process in severe mental disorders is the recovery and reconstruction of a functional sense of self in the midst of persisting dysfunction [73]. In this process, spirituality and religion may play a central role in many patients' lives [74]. When exploring the way of "being-in-the-world"

of people with schizophrenia, we observe that frequently rehospitalised patients are prone to adhere to a normative ideal of social integration coupled with a sense of being excluded from this field; non-rehospitalised patients may develop a global detachment toward the importance of interpersonal and instrumental social roles, placing a positive value on withdrawal. In this positive withdrawal, religious signifiers often restore a valued sense of self and of existence [75]. Based on the role theory and depth psychology, religion provides some patients with identification models which, with the active support of the religious community, can facilitate recovery [76]. However, it is important to bear in mind that spiritual and religious concerns may become part of the problem as well as part of the recovery: some people recount that they experienced organized religion as a source of pain, guilt or oppression. For some patients, it was a positive resource for recovery and the faith community was welcoming and hospitable, while for others, it was stigmatizing and rejecting. Some felt uplifted by spiritual activities, others burdened by them. Some felt comfort and strength in religiousness, others felt disappointed and demoralized [78].

Implications for clinical practice

This review permits us to ascertain that the relationship between religion and schizophrenia ranges from the worst to the best, as we can observe in the history of religion in humankind. Spiritual or religious commitment can lead to violent behaviour and refusal of treatment but also to helpful psychiatric care, social support of the religious community, and helpful strategies for coping with the illness and reconstructing the self as a legitimate person. Thus, in each person, a specific pattern of relationship between his or her psychotic disorder and religion can be elicited.

This review has pointed out that religion is not only important for people with schizophrenia, but that it is also relevant to psychiatry. Considering spirituality and religion in the treatment of people suffering from schizophrenia may help to reduce pathology, enhance coping and foster recovery. Not addressing this issue may lead the patient to dismiss spirituality and religion and thus loose potential coping and recovery strategies: "Psychiatrists take a great power over us … I have the impression that the physician doesn't agree for me to be religious … I ask myself if it was not an error to have left the idea of God for the idea of ET" (subject 2).

Religion and spirituality cannot be reduced to biological mechanisms (functioning of the brain), psychological mechanisms (psychopathology and coping) or social mechanisms (social support, cultural context). Religion cannot be reduced to a therapeutic tool for people suffering from schizophrenia. Spirituality and religion belong to the realm of the sacred. Mental health workers wishing to enter this field need to tolerate diversity, respect the beliefs of others, and refrain from proselytizing [79]. They also need to have knowledge of their own religious or spiritual identity [17]. A patient said: "I believe there is something essential, it is the respect of others' beliefs, because intransigence is not a good advisor … People who are against religions or religious peoples shut themselves up in a dangerous logic, it is the basic principle of cults" (subject 73). Moreover, our ongoing study shows that, if asked to discuss spiritual topics with their physicians, most patients would feel at ease [3].

This exploration of the relationships between religion and schizophrenia leads us from pathology and coping with illness to the necessity of taking into account spirituality when caring for people suffering from schizophrenia. Especially regarding the people's subjective experience, a woman said: "The nun always told me that the gospel is the world upside down and I didn't understand and one day, I saw all my life. I was so ashamed of myself, I have done so many silly things, I was a wreck and I told myself "I have a dignity in God, I am a person, even if I am schizophrenic, on welfare, I am a person" (subject 19).

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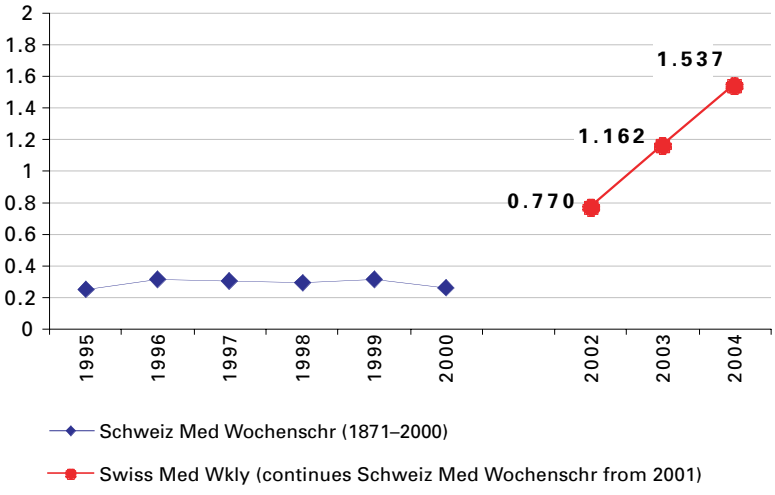

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