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REVIEW

Religion, spirituality and depression: implications for research and treatment

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ABSTRACT

Background: There has been a recent interest in religion and spirituality in psychiatric research and practice.

Scope: After outlining the problems involved in examining religious/spiritual variables in psychiatric research, this review examines the relationship between depression and various measures of being religious. A search of databases containing published literature on religion and depression was carried out using the databases PubMed, Psycinfo and Medline from 1996 to 2006.

Findings: The literature suggests that those who are religious have a lower incidence of depressive symptoms/depression and that being religious may increase the speed of recovery from depressive disorder. This protective effect is less clear cut for psychotic depression.

Conclusions: This review ends by discussing the clinical implications and potential areas for future research.

Introduction

Traditionally psychiatry has held a negative attitude towards religion, with mental health professionals seeing religious belief as antiquated, dependency and guilt inducing. It is of no surprise that religious issues are rarely discussed in psychiatric interviews unless they constitute part of the psychopathology. In fact the Danish theologian Hans Kung referred to religion as 'psychiatry's last taboo'[1]. An ex-president of the UK Royal College of Psychiatrists, however, bemoans the fact that psychiatrists have for a long time ignored spiritual issues[2].

A number of recent authors have underscored the importance of mental health professionals taking into account patients' religious and spiritual lives during the psychiatric consultation[3-6]. There is evidence that the general public and psychiatric patients report themselves to be more religious and attend church more regularly than mental health professionals[7]. One Gallup poll in 1985 indicated that one third of the general population considered religion to be the most important dimension of their lives. Another third considered it to be very important[8].

This review firstly examines the problems looking at religion and spirituality in psychiatric research and then moves on to specifically discuss religion and well being, hope, self-esteem and depression. Depression has been selected since it is the most common and treatable of mental disorders and is often associated with loss of hope and meaning. These are the very things that religion and spirituality purport to offer.

The past ten years have seen a growth of studies examining the relationships between religion and mental health. These studies have been remarkably diverse in scope, quality and objectives reflecting the fact that scholars have presumed that religious factors are potentially influential in mental health. There have been several major reviews published during the past decade[9-12]. This review builds on these reviews but expands them to include recent work on spirituality, cognitive psychology and their implications for working with depressed patients. Unlike previous reviews which largely focus on the USA, it includes studies conducted in the UK.

The problem of operationalising religion

There are a number of difficulties looking at this area. First, the definition of what constitutes religion is controversial. Is religion a uni-dimensional or multi-dimensional phenomenon? Researchers have generally seen religion as multi-dimensional and have typically divided it into a number of dimensions: belief, affiliation or denomination, organisational religiosity (participation in church or synagogue activities), non-organisational religiosity (private prayer), subjective religiosity (importance of religion in one's life), religious commitment, religious experience, religious knowledge and religious well being and recently religious coping. One major advance in the study of religion and mental health derives from Gordon Allport's[13] notion of intrinsic and extrinsic religion. Intrinsic religion refers to being religious for its own sake, whereas extrinsic religion refers to being religious for any benefit it may bring. Significantly intrinsic as opposed to extrinsic religiosity has been found to relate to better mental health outcomes using a number of measures.

There is a lack of clear direction in what constitutes outcome measures in terms of mental health. Studies have ranged in their outcome measures from well being to hope and optimism, to purpose and meaning in life, to greater self-esteem to less loneliness, to looking at rates of specific psychiatric disorders, such as, depression, suicide, anxiety, schizophrenia and alcohol and drug abuse.

Studies to date have been limited to Judeo-Christian religions. There is relatively little work examining the relationship between religion and mental health in Eastern religions. Research using other populations, such as African, Americans, Asians, Latinos, Muslims and Jews needs to be done to look for healthfulness and harmfulness of religion. It may be that findings related to Western monotheistic religions cannot easily be transferred to other religious groups. Indeed we cannot take Judaism or Christianity as homogenous groups; there is a further need to define subgroups within these mainstream groups.

The vast majority of the research on religion and mental health has been conducted in the USA. There is a difference in culture between the UK, Europe and America which might render the results of such studies difficult to generalise to the UK and Europe difficult. Religious groups are different in different cultural settings and are influenced by changes associated with modernisation and globalisation.

Lastly, studies on religion and mental health are generally quantitative, and qualitative studies are rare. Such qualitative studies might further our knowledge of the intervening links between mental health and religion by emphasising the role of individual religious/spiritual experience and its psychological effects.

Religion and spirituality

Over the past ten years researchers in this field have broadened their horizons to examine 'spirituality' as a variable in mental health research[14]. However, the difference between religion and spirituality remains far from clear and the distinction may be culturally specific[15]. The term spirituality has been used in variable and often contradictory ways in the literature. To date, studies have imposed definitions of religion and spirituality on informants and little work has been done on how lay people conceptualise these areas themselves. 'Spirituality' has typically been defined as a personal relationship with a 'higher power' and the sense of meaning deriving from this relationship (usually but not always God), whereas religion is associated with institutionalisation and a community. It is possible to be spiritual but not religious and there is a growing literature suggesting that in Western cultures there is increasingly a move towards individual spirituality. For some 'new age' seekers, spirituality relates to a close relationship with 'nature' and has little to do with transcendental relationships with a higher power. To date, studies on depression have largely focused on religion with little examination specifically of spirituality.

Methodology

A search of articles published in the academic literature from 1996 to 2006 was conducted. A number of computer databases were searched: PubMed, Psycinfo, Medline using the keywords religion, spirituality, depression, treatment and life event. Studies examined all age ranges from adolescence to the elderly. In all, 70 studies were found. Although this is not a systematic review, the studies discussed below were chosen for their methodological rigour.

Religion, well being, hope and optimism

Koenig et al.[12] in a comprehensive overview of the topic which critically examined one hundred studies examining the association between religion and well being, reported at least one significant positive correlation between these variables in 80% of the studies. While the correlations reported by many studies are modest, they equal or exceed correlations between well being and other psychosocial variables, such as social support. Similarly 80% or more of the studies reported a positive correlation between religiousness and greater hope or optimism about the future. Hence it appears that being religious might enhance a sense of hope which could possibly influence rates of depression.

Self-esteem

Of 29 studies examining the relation between religion and self-esteem, 16 (55%) reported greater self-esteem among the more religiously involved. Krause[16] reports that feelings of self-worth tend to be lowest for those with little religious commitment. The close relationship between low self-esteem and depression has been pointed out by a number of authors[17] and again self-esteem may mediate between religion and depressive symptoms/illness.

Depression

The author found 70 studies (cross-sectional and longitudinal) examining the relationship between being religious/spiritual and the prevalence of depressive symptoms and depression. The majority of these (42) found less depression among those who were more religious. A representative sample of these studies is discussed below. There is also some evidence that religious interventions may increase the rate of recovery from depression. Koenig et al.[18] found that among 87 clinically depressed older adults who were followed for one year beyond the onset of depression, intrinsic religiosity was directly proportional to the speed in which their depressive episodes abated. This association appeared to be stronger amongst those subjects whose physical disabilities did not improve over the follow-up period.

Several recent studies[19,20] point out that certain aspects of religiousness (public religious involvement, intrinsic religious motivation) are inversely related to the incidence of depressive symptoms. Bram et al.[19] found public religious involvement (church attendance) was inversely related to rates of depression amongst elderly individuals from several European countries. Depression rates were lower among regular church attenders, most prominently among Roman Catholics. In a study of clinically depressed adults, Murphy[20] found that the incidence of depressive symptoms was inversely correlated with religious beliefs after controlling for age, race, marital status, gender and educational level.

A representational longitudinal study of 2,836 adults from the general population[21] examined the relation between religious involvement and the frequency of symptoms of depression and found a curvilinear relationship. Although religious attendance was found to have little relationship with symptoms of depression, once demographic and physical health variables were controlled, there was a significant correlation between religious 'salience' and symptoms of depression. Individuals who did not see themselves as religious and individuals who saw themselves as extremely religious had more frequent symptoms of depression than those who considered themselves moderately religious.

A meta-analytic review of 150 studies of depression and religion found some evidence for an association between religiousness and depression[22]. This association was very strongly negative in studies in which participants could be assumed to be under severe levels of stress i.e. those who were more religious had less depressive symptoms. They also found that people with high levels of religiousness had slightly lower reports of depressive syndromes. There was evidence suggesting that overt measures of intrinsic religious motivation (i.e. the extent to which one reviews religion as the master motive in one's life)[13] were modestly negatively related to depressive symptoms.

Extrinsic religious motivation (involvement in religion as a means to other ends and negative forms of religious coping) related to a higher frequency of depressive symptoms. The findings suggest that assessment of the multi-dimensional aspects of religiousness, as well as the specific ways people use religion to cope with stress, may provide particularly useful windows for examining the possible impact of religious involvement on depressive symptoms. The authors conclude that the evidence supports many researchers' perceptions that some aspects of religiousness are indeed related to better functioning on some measures of mental health.

Swinton[23] conducted a small qualitative study using six people who had experienced depression for at least two years. His findings emphasised the importance of having meaning or purpose in their lives and how this sense of meaning was diminished by their illness. This loss and its associated rediscovery were central aspects of both depression and spirituality. Spirituality may provide such a sense of meaning through its emphasis on liturgy, worship and prayer found in the major religious traditions.

In another study of the influence of spirituality on mental health in adulthood, one author[24] describes an inverse relationship between four dimensions of spirituality – meaning of life, intrinsic values, belief in transcendence and spiritual community – and symptoms of depression.

How might religion influence the development of depressive illness?

The evidence cited above suggests an inverse relationship between being religious and the frequency of depressive symptoms. Since the majority of studies are cross-sectional we cannot infer causality. It may be that those who are depressed might devote less time in religious activities. However the relationship between increased religiosity and lower rates of depression/depressive symptoms is fairly robust. How might this finding be accounted for?

There is no research which has specifically examined genetic factors which might mediate

between the two variables. Developmental influences may play a part. It may be that those developmental factors which enhance resistance to depression might facilitate religious behaviour. The reverse may occur. For instance sexual abuse may both lead to depression and may detract from religious practice. This is a potential area for future research

Another factor might involve the prohibition against drug and alcohol abuse in religious people. Indeed there is some evidence that religious groups endorse moral prescriptions and discourage interactions with those who abuse drug[25]. For example both in Judaism and Christianity, the excessive use of alcohol is strongly discouraged and in Islam it is totally forbidden.

The association between religion and social support has been widely discussed in the literature. It is well recognised that social support protects against depressive symptoms[12]. Being a member of a religious group enhances the provision of social support and thus may be a factor mediating the religiosity/depression relationship.

Religious coping

Recently attention has shifted away from being religious to the particular uses of religion as a form of coping. Pargament[26] provides evidence that specific types of religious coping are associated with positive psychological outcomes following a traumatic life event. Perceptions of support, a partnership with God and guidance from God at times of stress appear to be helpful in coping. One study[27] asked patients with various kinds of cancer how much they felt God was in control of their illness. Those who attributed more control over the illness to God reported higher self-esteem and better adjustment, according to the ratings of nurses. Overall, Pargament and Brant [28] conclude that religion can be helpful, harmful or irrelevant to adjustment. The results seem to depend on several factors: the method of religious coping, the sample, the situation and the timeframe.

The role of cognitive appraisal

Religion may provide a cognitive framework that enables a healthier appraisal of those stressors that do occur through the provision of meaning and coherence in people's lives. This may provide greater psychological resilience in the face of negative life events. Suffering is given a meaning in the world religions although there is marked variation in how this is done. It is not necessarily seen as destructive or humiliating, to be avoided at all cost. For instance, although the situation is far from simple, some Christians, Muslims and Jews see suffering as having an 'educational' value in that God provides negative experiences such that we can learn from them. Another common explanation of suffering is that it happens for the best but we as humans cannot understand God's purpose. In terms of coping many religions encourage active problem solving to a point then advocate acceptance and turning the problem over to God: "Lord grant me the ability to change the things I can, accept the things I can't and the wisdom to know the difference". A religious person may change the focus from himself to other people with worse suffering – a form of distraction.

Gall et al.[29] have provided a transactional model of the role of religiosity and spirituality in coping with life events. Spirituality is seen as a complex multifaceted construct that manifests in the process of an individual's behaviour beliefs and experience. Spiritual factors mediate the effect of stressors by influencing, appraisals, coping behaviours (e.g. prayer, use of ritual), problem solving and provide a sense of meaning to the experience. They interact in a dynamic manner and mediate between the stressor and the eventual psychological response. The ability to make meaning following a stressful life event might promote successful coping and adaptation and well being, whereas the inability to provide this meaning might result in inactivity and the inhibition of effective coping behaviours.

Religion and psychotic depression

Although there has been little attention specifically given to this topic by researchers, one author[30] found little evidence supporting a religious influence on psychotic illness including bipolar disorder and major depression. This author points out that there is consensus among researchers in this field that psychotic illnesses are largely biological in origin and that religious factors are unlikely to play a major role in the aetiology of psychotic depression

The negative effects of religion

Although much of the literature is suggestive of an overall positive effect of religion on mental health generally, we cannot ignore the fact that at times religious practice might have a deleterious effect on mental health. This may occur in a number of ways. Excessive devotion to religious practices might result in family break-up if the sole preoccupation of one spouse is towards religious practice. Differences in the levels of religiosity between spouses may result in marital disharmony. Religion can promote rigid thinking, overdependence on laws and rules, an emphasis on guilt and sin, and disregard for personal individuality and autonomy. Some psychiatrists have

argued vehemently that religion is not only irrelevant but actually harmful to patients and therefore should not be taken into account for health provision[31]. This is not generally borne out by the literature. In fact the author was only able to find one study empirically demonstrating that religious people were more likely to suffer with depressive symptoms[32]. Excessive reliance on religious rituals or prayer may delay seeking necessary help for their mental health problems, leading to worsening the prognosis of psychiatric disorder. At the most extreme, strict adherence to a 'religious philosophy' might precipitate suicide as occurred in rare new religious movements such as the Branch Davidians at Waco[33]. Again this area requires further empirical investigation.

Discussion of implications for treatment of affective disorder

The fact that religious factors might protect against the influence of negative life events suggests a possible need to incorporate religious perspectives into mental health care and for psychiatrists to include a brief religious assessment as part of their everyday working practices. At the least, mental health professionals should inquire about religious or spiritual faith and the role it plays in a person's life and whether they have appealed to their religious beliefs and practices as a mode of coping with current stressors. One useful assessment tool, labelled HOPE, emphasises sources of hope (H), the role of organised religion for the patient (O), personal spirituality (P) and end of life decisions(E)[34]. In terms of religious therapies, there is emerging evidence that religious or spiritual activities may lead to a reduction in the frequency of depressive symptomatology and that religiously accommodative psychotherapy is as effective as secular therapy for the treatment of depression among those who are religious and may be more highly valued by them[35]. One study compared the efficacy of religious and non-religious cognitive behavioural therapy (CBT) for the treatment of depression in religious individuals and found that the Christian-based CBT achieved a faster decrease in depressive symptoms than secular therapy[36].

There may be a need to bring in religious professionals such as chaplains into mental health teams[37]. A chaplain may be seen as the legitimate person to whom spiritual issues may be addressed and can provide a model of 'holistic care'. However chaplains do require training in mental health issues. Just as mental health professionals require a knowledge of religious issues to prevent the pathologisation of religious states, so too do chaplains require a basic knowledge of mental health issues to ensure that they can pick up major mental illness and refer people for appropriate help.

Conclusion: Implications for future research

The above discussion is strongly suggestive of a relationship between religious factors and depression. The response to life stressors may be directly mediated by religious/spiritual factors which provide a framework for providing meaning. There are several potential areas for future research. First researchers need to differentiate more clearly religion from spirituality and to examine their specific effects on mental health. Research needs to be broadened to include non-Christian groups and those who follow Eastern traditions. In relation to this there is a need to move beyond the form of religious activity to assess how different theological traditions and their various conceptualisations of the Divine provide cognitive frameworks for dealing with life events and thus impact on mental health and well being. There is a need for more qualitative studies which can delve into the meaning and relevance of spirituality for individuals not always accessible by structured questionnaire or survey methods. Studies on depression need to separate out religion's effects on different types of depression from mild to severe psychotic depression. Lastly there is need for studies which look at the assessment and manipulation of religious variables in treatment. There is no doubt that there is much for future researchers to examine in this fascinating field.

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