

# Religion and mental health



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This assignment differentiates between the concepts of spirituality and religion and analyzes the strengths and weaknesses of the research findings related to spirituality, religion, and mental health. The purpose is to discuss the importance of clarifying values and becoming self-aware in relation to implementing spiritual and religious interventions. The components of spiritual assessment are presented as well as spiritual coping practices and interventions the nurse might use when working with clients.

Spirituality and religion are too often neglected foci of psychiatric mental health assessment and intervention. In order to maximize therapeutic effectiveness, nurses should be aware that for many patients spirituality is a critical life factor. Accordingly, they should screen patients and strive to meet patient needs for spiritual expression, while recognizing that there are important boundary and ethical issues in psychiatric mental health settings.

**Search terms: Spirituality, religion, ethics, mental health practices.**

**Psychiatric-mental health nurses concern themselves with people's suffering and the alleviation of that suffering. Suffering in the context of psychiatric-mental health nursing is uniquely multilayered and multileveled, involving body, mind, and spirit, and often challenging personal meaning systems. Indeed, because the nursing profession espouses a holistic, body-mind-spirit view of humanity, nurses are obliged to acknowledge and appreciate the physical, emotional, and spiritual uniqueness of each patient under their care (Burkhardt & Nathaniel, 1998).**

**Research has shown that patients want to be seen and treated as whole persons, not as disease states (Astrow, Puchalski, & Sulmasy, 2001; Koenig, McCullough, & Larson, 2000). Being a whole person implies having physical, emotional, social, and spiritual dimensions. Ignoring any of these aspects of humanity may leave patients feeling incomplete and may even interfere with healing (Koenig et al., 2000).**

For many patients, spirituality is an important part of wholeness. When caring for patients in psychiatric settings, as in any other healthcare setting, nurses cannot ignore that part of personhood. Spirituality also may represent a value that is foundational to many patients' lives. Good nursing care requires nurses to know their patients and the values they consider most important in their lives. It also requires nurses to know themselves, develop an awareness of their own values, and establish a degree of competence in recognizing and addressing the spiritual needs of their patients.

Psychiatric nurses are aware that their patients often have religious delusions and sometimes religiously oriented hallucinations (American Psychiatric Association, 1994). Sorting these from true spiritual distress or from the squeals associated with ritualistic or cult abuse can be challenging. On the one hand, spirituality and religion are important elements of a human being's personhood; on the other, reinforcing patients' delusions can be dangerous. In order to render individually based, holistic, and ethical care, practitioners should be aware of the perspectives and controversies surrounding certain concepts in the care of mentally ill people that have religious or spiritual overtones.

This assignment discusses the concepts of spirituality and religion and their importance in the context of mental health and illness. It presents religious and spiritual interventions in mental health care. In addition, it reviews some ethical considerations of meeting clients' unique spiritual needs.

## **Spirituality and Religion**

Despite millennia of debate, there is little consensus on the meanings of spirituality and religion. Spirituality and religion often are used interchangeably; however, there are important differences. Spirituality has been described as a person's experience of, or a belief in, a power apart from his or her own existence. It also has been described as an individual search for meaning (Bown & Williams, 1993). Less is known about spirituality outside the context of religion because the concept is amorphous and difficult, if not impossible, to define (Booth, 1995) and explore (Thomason & Brody, 1999). Spirituality may exist within a person but is ultimately apart from him or her. It is the sense of relationship or connection with a power or

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force, but that force or power need not be a deity. Not every person who professes to be spiritual is also religious or even believes in a deity.

Agnostics and atheists can have a rich spiritual life despite the lack of a deity in their belief systems. At its core, spirituality consists of all the beliefs and activities by which people attempt to relate their lives to God, a divine being, or some other conception of a transcendent reality. Spirituality is not just the creation of individuals; it is shaped by larger social circumstances and by the beliefs and values present in the wider culture (Wuthnow, 1998).

Religion is the outward practice of a spiritual system of beliefs, values, codes of conduct, and rituals (Speck, 1988). It is an organized system of practices and beliefs in which people engage. Religion is a platform for the expression of spirituality and is an important factor in the lives of most Americans.

Surveys of the U. S. population during the past 60 years have established that religion holds a central place in the lives of many Americans (Gallup, 1990). Ninety-five percent of Americans believe in God. More than 50% pray daily, and almost 75% of Americans say that their approach to life is grounded in their religious faith (Bergin & Jensen, 1990; Gallup, 1996).

Ninety percent of Americans consider religion “ very important or fairly important” in their lives (Gallup, 1996).

In more recent surveys 77% of Americans were found to believe the overall health of the nation depends a great deal on the spiritual health of the nation; 72% said their lives have meaning and purpose because of their faith; 60% said their faith is involved in every aspect of their lives (Gallup & Johnson, 2003). The findings are similar in Canada.

## **The Importance of Spirituality, Religion, and Mental Health**

Because many people do not distinguish between the concepts of spirituality and religion, most research linking spirituality to health has measured religious beliefs or practices. Research on spirituality as manifested by a faith in a higher power, however, recently has experienced a surge of interest, and spirituality measures are being developed that may assist in future research (Post, Puchalski, & Larson, 2000).

Religion provides many patients with social support as well as a clinically effective cognitive schema that enhance well-being and lower distress (McIntosh, Silver, & Wortman, 1993). Religious involvement predicts successful coping with physical illness (Koenig et al., 1992; Koenig, George, & Peterson, 1998). High intrinsic religiousness predicts more rapid remission of depression, an association that is particularly strong in patients whose physical function is not improving (Koenig et al., 1998).

An estimated 350 studies have examined religious involvement and health. Most of these have found that religious people are physically healthier, lead healthier lifestyles, and require fewer health services (Koenig et al., 2000) than those who are not religious. During the past three decades, at least 18 carefully controlled prospective studies have shown that religiously involved people live longer (Mueller, Plevak, & Rummans, 2001) and that highly religious people had a 29% higher odds of survival compared with less religious people (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000).

Researchers have also found that religious practices may have a greater influence on American teenagers than previously realized (Gallup & Bezilla,

1992). Studies consistently indicate that adolescent religious involvement is associated positively with prosocial values and related negatively to at-risk behaviors, including suicide, substance abuse, delinquency, premature sexual activity, and adolescent pregnancy (Gallup, 1990).

Religious commitment also may be related to a lower incidence of substance abuse. Studies link alcohol and other drug abuse to a lack of purpose in life, which often is associated with low levels of religious involvement (Black, 1991).

Furthermore, more than 850 studies examined the relationship between religious involvement and various aspects of mental health. Between two thirds and three quarters of these studies have found that people who are religious experience better mental health and adapt more successfully to stress than those who are not. Researchers have shown an important relationship between religious commitment and positive mental health status among older adults (Koenig et al., 1992). Many seniors who practice their faith have decreased levels of depression, anxiety, and alcoholism; experience higher life satisfaction and greater wellbeing; and adapt better to the rigors of personal loss, physical illness, and disability (Koenig, 1997).

Religious involvement has been associated with less anxiety (Koenig, 2001). Twenty-four studies in the research literature have found that religiously involved people had fewer depressive symptoms and less depression (Mueller et al., 2001). Research also suggests that, in addition to protecting against depression, higher levels of religious commitment may afford protection against one of the most severe outcomes of depression-suicide.

Gartner, Larson, and Vacher-Mayberry (1990) conducted a review of empirical studies on the relationship between religious commitment and mental health and found that religious commitment was related inversely to suicide in 13 of 16 (81%) of the reviewed studies.

Religious commitment also has been found to moderate the relationship between functional disability and depression. As religious commitment increased, the relationship between disability and depression weakened. Koenig et al. (1992) found that the positive correlation between disability and depression was strongest among the least religiously involved subjects and weakened progressively among people who were most likely to use religion as a coping strategy.

Despite these findings, readers are cautioned that published work on religion and health has been criticized on methodological grounds. Researchers have failed to control for confounding variables and other covariates, as well as to control for multiple comparisons using multiple statistical procedures. For example, confounders such as behavioral and genetic differences and stratification variables such as age, sex, education, ethnicity, socioeconomic status, and health status may have an important role in the association between religion and health. Failure to control for these factors can lead to a biased estimation of this association. Likewise, many studies on religion and health fail to adjust for the greater likelihood of finding a statistically significant result when conducting multiple statistical tests (Berry, 2005).



## **Negative Effects of Religious Involvement and Spirituality**

Few systematic studies have shown that religious involvement and spirituality are associated with negative physical and mental health outcomes. Like any other lifestyle choice, religion can have adverse consequences. For example, religious beliefs can affect a person's health by encouraging avoidance or discontinuance of traditional treatments or leading to a delay or failure to seek timely medical care. In some cases, religious beliefs may support physical abuse of children. A consistent pattern of physical abuse may occur in some families that generally starts as corporal punishment, and then gets out of control. The punishment is justified on religious grounds (Straus & Yodanis, 1994). The Bible contains a number of verses that, if taken literally, support severe physical punishment of children. One example is Proverbs 23: 13-14: "Withhold not correction from the child: for if thou beatest him with the rod, he shall not die. Thou shalt beat him with the rod, and shalt deliver his soul from hell." Also supporting extreme corporal punishment is Proverbs 20: 30: "The blueness of a wound cleanseth away evil: so do stripes the inward parts of the belly." And Proverbs 13: 24 seems to advise a quick resort to such punishments: "He that spareth his rod hateth his son: but he that loveth him chasteneth him betimes."

Passages such as these were found marked in the home of a Christian fundamentalist in Oregon who had so severely and frequently beaten his 6-year-old daughter that she became brain damaged and comatose.

Practices associated with religions can be deadly in the wrong hands. The literature contains several reports of fatal salt water intoxication following an exorcism session (Hedouin et al., 1999) including a fatal salt intake by a

woman suffering from postpartum depression in which reports indicate that she had the highest ever documented sodium plasma level (Ofra, Lavi, Opher, Weiss, & Elinav, 2004).

People who are preoccupied with religion may have unrealistically high expectations for themselves, leading to isolation or alienation from those who do not share their beliefs. Finally, it is well known that unhealthy, fanatical belief systems can affect physical and mental health adversely (Mueller et al., 2001).

### **Spirituality, Religion, and Mental Illness**

Religious and spiritual themes, as manifested in mental illnesses, vary.

Psychopathologic distortions of normative religious beliefs can be seen in patients with schizophrenia or bipolar disorder. Some of these patients may believe that they have special powers given to them by divine sources. They may believe that these powers can influence the outcome of world events in wondrous or in nihilistic ways. In some florid stages of psychosis, they may believe that a deity is speaking to them or guiding their actions. Some may even believe that they are deities themselves and have special divine missions.

On another level, highly stressful life events can transform normative religious beliefs into excessive preoccupations that involve self-blame and guilt over real or imagined transgressions. Without relief from this stress, patients may exhibit psychotic distortions that involve religious themes. Very depressed people may see themselves as being damned, with no hope of salvation and in need of punishment by their God. Some may believe that

their transgressions are so severe that they cannot be saved or forgiven, and they may become suicidal.

Nurses must use caution when approaching the subject of spirituality or religion with patients whose severe illnesses have a strong religious overlay. Richards and Bergin (1997), scholars who are committed to spiritual strategies in psychotherapy, counsel that spiritual intervention and exploration can be relied on more readily in less disturbed patients. By “less disturbed” they mean people with moderate anxiety and depression, self-esteem problems, adjustment difficulties, and interpersonal, family, or marital problems. As the severity of the patients’ disorder increases, more technical and somatic interventions such as hospitalization, electroconvulsive therapy, or medication are more appropriate. Although they agree that spiritual interventions can be important components of treatment with more disturbed patients after somatic therapies have been instituted, they specifically state that spiritual interventions are contraindicated in patients who are delusional or psychotic.

### **Clarifying Values**

Values are ideals or beliefs that are important to people and that in large part determine how they will act and behave. Family background, peer interaction throughout the lifespan, and secular and religious education influence values and ways of thinking (Boehnlein, 2000). Values help us make decisions and influence our behavior. Nurses and other healthcare providers do not enter into a clinical situation as blank slates. Rather, they come with assumptions, preconceived ideas, and worldviews that make

them most comfortable within prescribed boundaries and familiar surroundings.

While values can drive behaviors toward others in important and productive ways, they also can be unproductive and sometimes damaging when they result in intolerance, prejudice, bigotry, or demonization of those who do not hold similar values. Cultural anthropology provides ample evidence of human beings' tendency to view people different from themselves as the "others" (O'Connell, 2000). Thus, nurses and other healthcare providers must develop an awareness of the influence of their values on their identity and professional life. Clarifying values is about discovering what people believe and what is important to them. It also involves becoming more conscious of what they value and how it might influence their attitudes and behaviors in clinical settings. Values clarification and self-awareness go hand in hand. When working with patients, nurses and other healthcare providers must become aware of their own personal values, their patients' values, and the differences between them. Self-awareness allows healthcare providers to act from their own spiritual or cultural perspectives, while taking care not to impose these values on others.

### **The Role of the Nurse in Mental Health Care**

The nursing literature contains many different views on the topic of spiritual assessment and intervention. Nursing theorists such as Watson (1985) and Roy (1984) clearly identify spiritual care as a nursing responsibility (Reed, 1992; Ross, 1994) and state that the provision for patients' spiritual needs is part of the nursing role (Carson, 1989). As mentioned above, however, the research literature on the benefits of spiritual and religious involvement is

inconclusive, and nursing studies substantiating benefits of nursing interventions is sparse in the psychiatric literature (Stuart, 2001). With respect to nursing interventions in the spiritual domain, they do not exist at all despite the fact that the North American Nursing Diagnosis Association (NANDA) recognizes Spiritual Distress and Potential for Enhanced Spiritual Well-Being as two nursing diagnoses.

Therefore, what should nurses do? They certainly should approach patients holistically as beings that are more than the sum of their parts. They should acknowledge and respect the spiritual lives of patients, and always keep interventions patient-centered.

Nurses are also encouraged to build collaborative relationships with patients' clergy and chaplains to learn more about spiritual interventions and the rich diversity of spiritual and religious views. They are encouraged to invite clergy to consult and to be members of the patients' treatment team. As patients express a desire for greater attention to spiritual issues in their care, structured collaborations can assist in providing those with mental health problems the balanced and holistic approach that they seek, but which is not always available to them.

## **Suggested Nursing Actions**

### Spiritual Assessment

Acknowledging the spiritual lives of patients may involve asking about that aspect of their lives when taking a history. A spiritual history is not appropriate for every patient. Some practitioners suggest four simple questions that might be asked of seriously ill patients:

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1. Is faith (religion, spirituality) important to you in this illness?
2. Has faith been important to you at other times in your life?
3. Do you have someone to talk to about religious matters?
4. Would you like to explore religious matters with someone?

The nurse can preface these questions by explaining that such information is important in planning for support services in the event that the patient develops a serious health problem (Astrow et al, 2001).

In addition, open-ended questions that allow patients to tell nurses about how they view relationships, the meaning of their illness, or what kinds of coping have helped them in the past can yield information about spiritual concerns and practices that may help nurses with plans of care (Burkhardt & Nathaniel, 1998). Conducting a brief spiritual assessment can help nurses better understand their patients' worldviews and help determine whether patients' religious and spiritual beliefs and community could be used as a resource to help them better cope, heal, and grow.

### Spiritual Coping Practices and Interventions

The nursing literature on spiritual coping strategies used by patients in illness is limited (Baldacchino & Draper, 2001) and focuses mostly on religious coping mechanisms. Knowledge of spiritual and religious coping practices can inform patient intervention. Richards and Bergin (1997) differentiate between religious and spiritual interventions on the basis of structure. Religious interventions are more structured, denominational,

external, cognitive, ritualistic, and public, whereas spiritual interventions are more ecumenical, cross-cultural, internal, affective, transcendent, and experiential. Because religion and spirituality are interrelated so closely in the healthcare literature, however, no distinction between the two is made in this section. Moreover, all strategies discussed later can be either ecumenical or denominational. Interventions should be agreed upon in partnership with patients. They should be tailored to patients' worldviews and unique personal coping mechanisms, in particular, those reported by patients to have helped them during past illnesses or crises.

In several situations, spiritual interventions are contraindicated:

- \* When patients are psychotic or delusional
- \* When patients have made it clear that they do not want to participate in these interventions
- \* With minors whose parents are unaware that their children are participating in activity contrary to their denomination and faith (this can result in unwanted legal repercussions)

## Prayer

People report that prayer is a powerful form of coping that helps them physically and mentally. Fifty-seven percent of Americans report praying daily (Boehnlein, 2000). Prayer is a kind of communication or conversation with a power that is recognized as divine. Prayer is practiced by all Western theistic religions and several of the Eastern traditions (e. g., Hinduism, Buddhism, Shintoism, Taoism). Prayer may differ in form and content from <https://assignbuster.com/religion-and-mental-health/>

religion to religion. Different kinds of prayer seem to have different effects on well-being and satisfaction, with group prayer being associated with greater well-being and happiness and solitary prayer being associated with depression and loneliness (Poloma & Pendleton, 1991). One national poll found that 48% of patients want their physician to pray with them, and 64% of Americans think that physicians should join in prayer with patients if asked (Yankelovich Partners, 1996). Whether nurses should join their patients in prayer if they ask is a personal choice. The nursing literature has addressed the subject of nurses praying with their patient with respect to its ethical or legal implications. One ethicist cautions, however, that the prayer should be led by an identified religious leader distinct from the medical team whenever possible so as to avoid even an appearance of religious coercion (Dagi, 1995). Moreover, Kaufmann (2000) counsels that prayer as an adjunct to appropriate treatment might seem innocuous at first blush but that praying with vulnerable patients could create a new source of liability if patients see themselves as being influenced unduly by practitioners.

### Bibliotherapy with Sacred Writings

Bibliotherapy involves the use of literature to help patients gain insight into feelings and behavior and learn new ways to cope with difficult situations. It has been identified as a process of interaction between the personality of the reader and the literature, which may be used for personality assessment, adjustment, or growth (Alpers, 1995; Finnegan & McNally, 1995). All major world religious traditions have some type of text or writing that their followers view as holy and that they use as a source of comfort, insight, wisdom, and guidance (Nigosian, 1994). The stories and narratives in these



writings can be a solace and inspiration for patients. Spiritual reading is a significant part of 12-step programs (Finnegan & McNally). Before recommending any literature to patients, nurses should consult with the treatment team, as well as with the patients' family and clergy.

### Contemplation and Meditation

Contemplation and meditation are types of mental exercises that involve calmly limiting thought and attention. There are several meditative traditions, for example, Zen, vipassans, visualization, transcendental, and devotional (Benson, 1997; Borysenko & Borysenko, 1994). All forms of contemplation involve isolation from distracting environmental noise, active focusing or repetition of thoughts or a word (mantra), muscle relaxation, release, and a surrender of control. Guided imagery is a popular form of meditation that uses visualization and can be augmented by music and voice on cassette tapes or CDs. Caution is urged in employing contemplation and meditation as an intervention without knowledge of a patient's denomination. Some forms of Eastern meditation may be viewed in an unfavorable way by Christian patients (McLemore, 1982). Moreover, contemplation and meditation may not be appropriate as interventions in patients with disorders that have paranoid ideation who may believe that their minds are being controlled.

### Repentance and Forgiveness

All major theistic world religions teach that people should forgive those who have harmed them and seek forgiveness from those whom they have harmed (Richards & Bergin, 1997). From a religious perspective, repentance

and forgiveness are viewed as acts with important spiritual consequences associated with admitting one's shortcomings and failings and making restitution. Forgiveness and repentance are integral parts of the 12-step programs (steps 4 and 5) practiced in Alcoholics Anonymous in public "confessions" and recounting of wrongdoing. The process of repentance can be intensely painful for patients. Forgiveness and repentance in psychiatric settings should be interventions that are within the purview of a pastoral counselor or clergyperson (Latovich, 1995).

### Worship and Rituals

All major religious traditions encourage their followers to engage in private and public acts of worship. Worship is the devotion accorded to a higher power or deity, and rituals are the ceremonies, rites, or acts such as prayer; singing hymns; fasting or abstaining from food, water, or sexual relations; and partaking of sacramental emblems. Acts of worship and ritual serve to express peoples' devotion to a deity. They facilitate their commitment or recommitment to a spiritual or moral life, offer settings and opportunities for solidarity with others, and provide for spiritual enlightenment (Smart, 1983). Benson (1997) suggests that worship services are full of "potentially therapeutic elements such as music, aesthetic surroundings, familiar rituals, distraction from everyday tension, prayer and contemplation, and opportunities for socializing and fellowship with others" (p. 176). Nurses should make certain that patients who wish to worship are given the opportunity to do so. Richards and Bergin (1997) caution that professional service providers should be careful about participating with patients in worship or ritual because of potential role boundary confusion.

## **Ethical Concerns and Conclusions**

This assignment discussed the importance of spirituality and nurses' obligations to recognize the importance of spirituality in their clients' lives. In closing, it is prudent to address some ethical concerns with respect to this area. Despite the promotion of spiritual interventions and the incorporation of patients' religious beliefs in their treatment by several enthusiasts and devout practitioners (Richards & Bergin, 1997; Tan, 1994), several scholars have raised ethical concerns. No responsible practitioner would advocate the abandonment of somatic treatments of mental illness. Clearly, patients who become so religiously preoccupied that it interferes with their day-to-day functioning or become destructive will need mainstream psychiatric care. Because research suggests that believers may use their religion as an additional way of coping with their illness, however, it is part of ethical practice for nurses to stay abreast of the debate and research pertaining to any clinically useful interventions.

All professionals have a privileged status with respect to people outside that profession. This status is privileged by virtue of the professionals' possessing what those outside the profession do not have-specialized knowledge (Freidson, 1986; Kultgen, 1988; Sokolowski, 1990). Thus, health professionals are in positions of great influence with respect to patients by virtue of their specialized knowledge or expertise. When they depart from areas of established expertise to promote a personal agenda or an area in which they are not expert, they abuse their status as professionals. Inquiries into a patient's spiritual life with the intent of making recommendations that

link religious practice with better health outcomes may represent such a departure (Sloan, Bagiella, & Powell, 1999).

A second ethical consideration involves the limits of the current research in this area. Religious or spiritual factors have not been shown convincingly to be related to health outcomes (Kaufman, 2000). Nurses must take care that they not misrepresent the state of the research, lest suggestible patients abandon allopathic treatment in favor of spiritual interventions to the detriment of their health.

A third ethical consideration is the danger of imposing one's own values on patients. Devout nurses may view their work as an extension of their religious beliefs. While there is no moral objection to discussing faith issues, preaching, teaching, or otherwise attempting to persuade patients to the nurse's religious or spiritual viewpoint is intrusive and unethical (Richards & Bergin, 1997). It is clearly a violation of boundaries and roles and may harm vulnerable patients. Such harm might happen if, for example, the nurse conveys that the patient is spiritually deficient or immoral because of a choice (e. g., abortion) with which the nurse may not agree. By the same token, it is also a clear violation of boundaries to engage in religious proselytizing. Examples of proselytizing are giving patients literature about nurses' spiritual tradition or denomination or teaching patients about religious beliefs when the patient has not requested such information or it is irrelevant to patient treatment goals.

Another ethical consideration raised by Richards and Bergin (1997) is that clinicians should pursue religious or spiritual goals and interventions only

when patients have expressed explicitly their desire to do so. They also recommend that clinicians using spiritual or religious interventions should always obtain informed consent from their patients and patients' parents where appropriate.

A final ethical pitfall has to do with the possibility of violating work setting (church-state) boundaries. Richards and Bregin (1997) advise professionals who work in civic settings to make certain that they understand and adhere to work-setting policies regarding the separation of church and state. In light of legal rulings about school p