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Religion and Mental Health

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العقيدة والصحة النفسية

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Abstract

Most religions have three components: supernatural belief system, a code of worship and a code of conduct.

Mental health involves competence in dealing with human environments without impairment of psychological functioning. Soft measures of individuals' religion pay attention to the worship system whereas hard measures look into the employment of the belief system in dealing with everyday stress and alleviating distress as a coping lifestyle. This study is a selective review on the relationship of religion to mental health and mental ill health. The role of religious belief system for self-regulation is more important for maintenance and restoration of mental health than the performance of the system of religious worship.

Key words: religion, mental health

Declaration of interest: None

Introduction

Most religions have three components: a supernatural belief system, a code of worship and a code of conduct. Health may be described as a state of physical, mental and social wellbeing. This definition does not include spiritual wellbeing. Mental health has both negative and positive components. The former refers to the absence of suffering during the performance of mental functions e.g. attention, perception, thinking, memory functions by the individual. The negative component of mental health also includes the refraining from inducing mental suffering into others. The positive component of mental health refers to the presence of psychosocial adaptation, i.e. the fit between an individual's capabilities and the requirements of his human environments including his/her work, family and general environments. The "fit" could be achieved by adapting one's abilities to environmental requirements, i.e. conforming or by adapting the environmental requirements to one's own abilities, in other words, mastery of the environment.[1] The positive component of mental health is sometimes known as competence.

Measures of religiousness

Religion may be measured by soft or hard measures involving respectively ritual performance (code of worship) and faith (cognitive code).[1] Mental health may be measured by soft or hard measures involving respectively overt mental functioning and competence. It is suggested that hard measures of religion may correlate with hard measures of mental health and that soft measures of religion may not have a consistent correlation with either measure of mental health.[2]

In evaluation of religiousness Larson et al. 3 considered 10 domains: affiliation in religious group activity, religious private practice, religious social support, religious coping with stress, religious values, religious commitment relative to other life areas, religious motivation to help reconcile relationships and unique personal religious experience.

Religion is an important constituent in most cultures.

Religion offers belonging to a group, an approved code of attitudes and behavioural norms (code of conduct) and a concept of later after-death life instead of the intolerable concept of a final irreversible death. Belonging to a religious denomination is socially conditioned by operant conditioning. The latter provides for positive reinforcement of religious belonging by social approval and social support and positive extinction of areligious and antireligious attitudes by social disapproval and even legal disapproval in some communities.

Religion and every day stress

In everyday mental life, religion is used to code rights and wrongs according to a superego formed by internalization of socially shared religious criteria. Religion helps to provide a meaning for stress[4] and its evaluation according to religious cognitive schemas. It instils hope in relief of the ensuing distress and sometimes emphasizes that, it is only the blasphemous who feel hopeless about the future.[5]

It encourages appeal to God by invocation to relieve distress and elicits support of members of the same religion in the face of stress. Religion also sets limits for personal responsibility in generation of stress and attributes failure to do good or failure to avoid wrongdoing to temptation by the devil. It encourages forgiveness of self and others at the expense of revenge. The system of faith beliefs is used for self-regulation and alleviation of distress.

Religious clergy are sometimes mediators between man and God, i.e. in confessions of wrongdoing and repentance.[6] Clergy could also guide believers to stipulations of their religious code of conduct or use religious verses to protect or relieve believers' distress attributed to evil spirits. Some religions allow the distressed themselves to practice self-help (autotherapy) by invocation of God or by restoring to their code of religious practice or to religious bibliotherapy.[7]

Religion and mental illness

Various studies reported the protective function of religion in reducing the risk of distress following adverse life events, reducing the risk of suicide. Guilt about blasphemous obsessive ruminations is reduced by attributing them to the devil. This helps to "understand" what would otherwise be non-understandable intrusive thoughts.[8] The religious elderly had milder depressions than their non-religious counterpart did. After-care by religious support groups was associated with lower rehospitalization rates in patients with schizophrenia.[6]

Religion provides an important background against which morbidity of thought content is measured in order to distinguish what is pathological from what is religiously shared in the community. The latter may involve magic thinking about the adversity of envy by others' evil eyes, the adversity of bad omens, or the adversity of black magic/sorcery. When the pathological edge of morbid thought content is lost with treatment, they could be contained in the religiously shared repertoire of beliefs. Thought content suggest mental ill health if they are associated with individual suffering, the induction of suffering in others and/or impairment of individual competence.[9] Azzoni and Raja[10] used these criteria in order to define delusions among pilgrims to the Vatican.

Religious and psychiatric practitioners

Until 1700 AD, British physicians needed a bishop's permission/license to practice. About 1800 AD the situation was reversed: the clergy had to be authorized by doctors to minister in the asylums.[6]

Religious healing practice is prohibited in some Arab countries, permitted in others and ignored in still others.11Some religious healers take up healing practice after personal experience of mental distress. Some psychiatrists engage in religious and biomedical treatments at the same time. Investigations into the advantage and disadvantage of religion to health are sometimes considered blasphemous. Religious and psychiatric practitioners are more likely to see patients representing each other's failures than each other's successes.[12]

For psychiatrists to use religious concepts in psychotherapy they need adequate knowledge of their patients' religion or religious sect. Psychiatrists should be able to identify religious "slots" in their patients' personal history or cognitive schemas where religious communication could "take" or fit. Globalized psychiatric medical treatment has also to be culturally adapted in order to suit patients from

a variety of cultures. Incayawar et al.[12] have described the unwitting partnership between traditional and psychiatric practitioners.

Religious healers on the other hand, indiscriminately use religious concepts for everybody, on all occasions, and across all sects or degrees of religiousness and regard as blasphemous all discussion on proof of usefulness or appropriateness of their dogmas.

Psychiatric practitioners try to undo patients' projection and encourage patients to develop an internal locus of control whereas religious healers reinforce patients' and relatives' projections on an external locus of control by supernatural agents.[12]

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الملخص

لغالبية الأديان ثلاثة مكونات هي مسلمات العقيدة وطقوس العبادة ومسلك المعتنقين للعقيدة. وتشمل الصحة النفسية كفاءة التعامل مع الآخرين بدون معاناة في أداء الوظائف النفسية. وتقاس العقيدة لدى الناس بمقاييس سطحية لقيامهم بطقوس العبادة أو بمقاييس متعمقة في قدرتهم على استخدام إيمانهم في التعامل مع ضغوط الحياة وفى تخفيف كرب المعاناة عند حدوثه. هذه المراجعة نوعية محددة في هذه العلاقة تشير الى الدور الذي تقوم به الأديان والمعالجين الدينيين مقارنة بما يقوم به الطبيب أو المعالج النفسي من أجل استعادة الصحة النفسية بعد الكرب النفسي ويقترح المقال أن استخدام منظومة العقائد الدينية لتنظيم الذات أهم للحفاظ على الصحة النفسية من أداء منظومة العبادات

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