



editorial

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HAROLD G. KOENIG

Religion and mental health: what should psychiatrists do?[†]

Religious beliefs and practices of patients have long been thought to have a pathological basis and psychiatrists for over a century have understood them in this light. Recent research, however, has uncovered findings which suggest that to some patients religion may also be a resource that helps them to cope with the stress of their illness or with dismal life circumstances. What are psychiatrists doing with this new information? How is it affecting their clinical practices? Studies of psychiatrists in the UK, Canada and the USA suggest that there remains widespread prejudice against religion and little integration of it into the assessment or care of patients. In this paper I discuss a range of interventions that psychiatrists should consider when treating patients, including taking a spiritual history, supporting healthy religious beliefs, challenging unhealthy beliefs, praying with patients (in highly selected cases) and consultation with, referral to, or joint therapy with trained clergy (Koenig, 2007). Religion is an important psychological and social factor that may serve either as a powerful resource for healing or be intricately intertwined with psychopathology.

At the end of the 19th century, French neurologist Jean Charcot, and later his star pupil Sigmund Freud, linked religion with hysteria and neurosis (Charcot, 1882; Freud, 1927). Over the next 100 years this would define the relationship between religion and psychiatry. Prior to the publication of DSM–IV in 1994, examples of people with mental illness presented in the DSM were often those of religious persons (Larson *et al*, 1993). These negative views toward religion were based largely on clinical experience, anecdotal reports and the personal opinions of influential psychiatrists. During the past 30 years, however, systematic research has accumulated – a review of literature on religion/spirituality and mental health prior to 2000 identified 724 quantitative studies (Koenig *et al*, 2001), but since then research in this area has increased dramatically. An online literature search in PsycINFO using the words ‘religion’ and ‘spirituality’ revealed 6774 articles published since 2000, about 50% being research studies. Does research confirm the connections between religious involvement, neurosis and mental illness?

While a few studies support such findings, the vast majority does not. In fact, of the 724 quantitative studies published before 2000, 476 reported statistically

significant positive associations between religious involvement and a wide range of mental health indicators (Koenig *et al*, 2001). Studies published since 2000 have largely confirmed these findings, extending them to negative and positive emotional states, across geographical location, and demographic and clinical characteristics (Koenig, 2008).

Psychiatrists’ beliefs, attitudes and practices

Four studies on the beliefs and clinical practices of psychiatrists in the UK, Canada and the USA have examined representative samples. In a study of British psychiatrists, Neeleman & King (1993) surveyed 231 psychiatrists at general and psychiatric hospitals in London: three-quarters (73%) of psychiatrists reported no religious affiliation (50% atheist or agnostic), 28% believed in God, and 22% attended religious services at least once a month. However, 92% believed that religion and mental illness were connected and that religious issues should be addressed in treatment, and while 42% believed religiousness could lead to mental illness, 61% said that it could protect against mental illness. With regard to psychiatrists’ practices, 48% said they often or always asked about the religious beliefs of patients, but two-thirds (66%) rarely or never made referrals to clergy.

A second and more recent study of British psychiatrists (Lawrence *et al*, 2007) focused on those working in old age psychiatry. Asked if they had religious affiliations, 58% replied affirmatively, a figure that is much higher than that for general psychiatrists (Neelam & King, 1993). Of these, 73% said they were Christian followed by Hindu, Muslim, Sikh, Jewish and Jain in that order. The majority (92%) recognised the importance of spiritual dimensions in their patients’ lives and a quarter considered referral to the chaplaincy service, but more complete integration of spiritual advisors into the assessment and management of individual cases was rare.

Baetz *et al* (2004) surveyed 1204 psychiatrists registered with the Royal College of Physicians and Surgeons of Canada and 157 Canadian patients: 54% of psychiatrists reported belief in God compared with 71% of patients. Psychiatrists were significantly less likely than patients to attend religious services or engage in private spiritual or religious activity. Less than half (47%)

[†]See invited commentary, p. 204, this issue.



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indicated it was appropriate to 'often or always' include religion/spirituality as part of psychiatric assessment and 50% often or always did so (although only 17% of patients said their psychiatrist often or always did). With regard to clergy referral, 55% said they at least occasionally do so (although 83% of patients reported their psychiatrist never did so). Among patients, 53% said it was important to have religion/spirituality addressed in their treatment, 47% thought it was important to know the religious orientation of their psychiatrist and 24% said it was a consideration in their selection of a psychiatrist.

In the USA, Curlin *et al* (2007a,b) conducted a study of psychiatrists and compared them with physicians from other specialties. There were 1144 physicians of multiple specialties systematically identified from across the USA, of whom 100 were psychiatrists. Compared with other physicians, psychiatrists were more likely to be Jewish (29% v. 13%), without religious affiliation (17% v. 10%), less likely to believe in God (65% v. 77%), less likely to attend religious services at least twice monthly (29% v. 47%) and less likely to rely on God for strength and support (36% v. 49%). With regard to clinical practices, 93% of psychiatrists (53% of other physicians) said it was usually or always appropriate to enquire about a patient's religion/spirituality, and 87% said that they usually or always did so (49% of other physicians); only 6% of psychiatrists said they prayed with patients more than rarely (20% of other physicians).

If the studies mentioned represent anything close to current attitudes and practices, then why is this so? Neeleman & Persaud (1995) provide some answers. First, psychiatrists are less religious than their patients and therefore may not appreciate the value of religion in helping patients cope with their illness. Second, since psychiatrists may often experience religion through the pathological expressions of individuals with religious delusions, this may bias them against religion as a therapeutic resource. Third, psychiatrists focus on the biological causes of mental illness and religion may be viewed as subjective and non-empirical. Finally, believing that religion causes dependence and guilt, psychiatrists may fail to appreciate its therapeutic value.

What should psychiatrists do?

Religion is relevant to British psychiatrists because many of their patients will be religious – the latest estimates suggest that only 12% of the British population is non-religious and atheists comprise only 1.4% (World Christian Database, 2007). There are sensible ways to address religion/spirituality in the care of psychiatric patients. Interventions include taking a spiritual history, respecting and supporting the patient's beliefs, challenging beliefs, praying with patients and referral to clergy (Koenig, 2007).

Taking spiritual history

The spiritual history should gather information about the patient's religious background and their experiences

during childhood, adolescence and adulthood, and determine what role religion played in the past and plays in coping with present life problems. Negative past experiences with religion are particularly important, including disappointments caused by unanswered prayers, major losses, or conflicts with clergy or other church members. Religious beliefs and activities important to patients should be explored, as well as their membership in a religious community, how active they are, how much support they receive, and whether this community is likely to oppose their psychiatric treatment. The information learned from the spiritual history will help determine the therapist's approach to the patient's religious beliefs (whether supportive, neutral, or challenging).

Intensely held religious beliefs can conflict with the type of therapy chosen and doom that method to failure (taking a spiritual history is especially important for patients in whom psychotherapy is planned) – negative attitudes toward traditional therapies are common among devoutly religious patients. The same applies for antidepressants or other psychiatric drugs, where religious attitudes may adversely affect compliance and treatment follow-up.

Even if the patient is not religious, the psychiatrist should gently probe further to obtain a better understanding of the patient's prior, if any, experiences with religion. Experiences that may have turned the patient off religion (such as sexual abuse by clergy or a traumatic event that altered their religious worldview) could be contributing to current psychiatric problems. If the therapist meets firm resistance from the patient, the topic should be tactfully dropped and perhaps approached at a later time after a therapeutic alliance has developed.

Respecting and supporting beliefs

The psychiatrist should always demonstrate respect for the patient's religious or spiritual beliefs, being aware that they often hold the patient's psyche together. Even bizarre or clearly pathological religious beliefs should be handled with respect, and attempts made to understand them. If beliefs do not appear obviously pathological and appear to facilitate coping, then the psychiatrist should consider supporting them. Care should be taken, however, not to move too quickly from enquiry about beliefs to supporting them. It is better to take a respectful but neutral position until the psychiatrist has a thorough understanding of the patient's psychopathology and underlying personality structure.

Challenging beliefs

When religious beliefs are contributing to or intertwined with psychopathology, a respectful but neutral stance is best initially. At some point, however, it may be necessary to gently challenge beliefs that are being used defensively to avoid making important life changes or attitudinal shifts. This is risky business and should not be attempted until a firm therapeutic alliance has been established, a thorough spiritual history has been taken,



and multiple attempts made to change the patient's attitude and behaviour in other ways. If the patient consents, a conversation with the patient's clergy (or a trained chaplain or pastoral counselor) before challenging the patient's religious beliefs may be helpful.

Praying with patients

Prayer with a religious patient can have a powerful positive effect and strengthen the therapeutic alliance. This, however, can be a dangerous intervention and should never occur until the psychiatrist has a complete understanding of the patient's religious beliefs and prior experiences with religion. Prayer should only be done if the patient initiates a request for it, the psychiatrist feels comfortable doing so, and the religious backgrounds of patient and psychiatrist are similar. Even if all the right conditions are present, there will be some patients for whom prayer would be too intrusive, too personal and may violate delicate professional boundaries. Prayer should never be a matter of routine. The timing and intention must be planned out carefully with clear goals in mind.

Consultation with clergy

Consultation, referral or joint therapy with a pastoral counselor or clergy with mental health training is most appropriate when spiritual needs or conflicts come up during therapy, when religious issues are mixed up with psychopathology and are blocking progress, or the therapist wishes to utilise the patient's religious resources in treatment. Consultation should be done sooner than later if the psychiatrist feels nervous, unprepared or inexperienced with these matters. Referral, however, should not be made before a thorough spiritual history has been taken, or before a therapeutic alliance has been established. Another option is to jointly treat a patient with a pastoral care specialist. Joint therapy, however, needs to be done carefully so that secular and pastoral therapies are in sync and do not conflict with one another. This may not work for some patients, particularly fragile individuals who may 'split' secular and religious therapists and spur competition between the two.

The American College of Graduate Medical Education mandates in its *Special Requirements for Residency Training for Psychiatry* (Accreditation Council on Graduate

Medical Education, 1994) that all programmes must provide training on religious or spiritual factors that can influence mental health. Ignoring the religious beliefs will cause the psychiatrist to miss an important psychological and social factor that may be either a powerful resource for healing or major cause of pathology.

Declaration of interest

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Harold G. Koenig Professor of Psychiatry and behavioral Sciences, Associate Professor of Medicine, Box 3400, Duke University Medical Center, Durham, North Carolina, USA, email: koenig@geri.duke.edu.