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Religion, Spirituality and the concept of Mental Illness

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The anti-spiritual bias in psychiatry has many roots, including questionable assumptions of Freudian psychoanalysis, behaviorism, and the overtly simplistic reductionism of materialists. The concept of mental illness differs in various cultures from possession of evil spirits, magic, evil eye, wrath of ancestors, lack of faith, other mystical beliefs, etc, to biological causes. Mental illness in Pharaonic Egypt, had no stigma, as no separation between psyche and soma. Mental illness in the Islamic era had three dimensions of the concept of mental illness. i) Possession (darkness), ii) Innovations and expansion of the self, iii) Disharmony or constriction of consciousness (enlightened). Positive aspects of religion and spirituality promote revolt against materialism, tolerance, mercy, virtue and justice. R/S include modifying role in our mental life, cultivate one's own integrity, reinforce internal courage, promote responsibility, provide meaning for individual or group, a protective factor for vulnerability to depression. On the other hand negative aspects of R/S justifies dependency, facilities acceptance of individual's deficiencies, allows extension beyond the limited individual boundary and may include religious fundamentalism, alienation and prejudice. WHO states that R/S plays a pivotal role in suicide prevention and promotion of mental health a plea to promote training of psychiatrists of R/S to have a better understanding of our patients.

Key words: Religion and spirituality(R/S), Mental Health, Transcultural aspects, R/C, Mental Illness

Religión, espiritualidad y el concepto de enfermedad mental

Las tendencias antiespirituales en psiquiatría tienen muchas raíces, incluyendo supuestos cuestionables del psicoanálisis freudiano, el conductismo, y el abiertamente reduccionismo simplista de los materialistas. La conceptualización de la enfermedad mental difiere dentro de diversas culturas y abarca explicaciones que van desde la posesión de espíritus malignos, magia, mal de ojo, ira de los antecesores, falta de fe, otros pensamientos místicos, etc, hasta causas biológicas. En el Antiguo Egipto la enfermedad mental no tenía estigma, dado que no había separación entre psique y soma. La enfermedad mental en la era islámica tenía 3 dimensiones: i) Posesión (oscuridad), ii) Innovaciones y expansión del yo iii) Disarmonía y constricción de la consciencia (iluminación). Los aspectos positivos de la religión y la espiritualidad: la tolerancia, compasión, virtud y justicia, promueven la revolución contra el materialismo. Religión/ Espiritualidad (R/E) implica un cambio de papel en nuestra vida mental, cultivar la integridad propia, reforzar el valor interno, promover la responsabilidad, dotar de significado a un individuo o un grupo y un factor protector para la vulnerabilidad a la depresión. Por otro lado, los aspectos negativos de R/E sirven para justificar la dependencia, la aceptación de deficiencias individuales, la superación de los propios límites y pueden derivar en fundamentalismo religioso, alienación y prejuicio. La OMS mantiene que R/E juega un papel fundamental en la prevención del suicidio y en la promoción de la salud mental una petición para promover la formación de psiquiatras en R/E.

Palabras clave: Religión y espiritualidad (R/E), Salud mental, Aspectos transculturales, R/C, Enfermedad mental

INTRODUCTION

WHO definition of health as physical, psychological and social wellbeing is incomplete, it neglects the spiritual wellbeing. The majority of world populations either believe in religion or spirituality. More than half of 6.8 billion world population believe in a heavenly religion while the other half in spirituality. Only a few people, whether agnostic or atheist, did not make up their mind regarding their relationship with an intelligent creator!!! Religion and spirituality play a pivotal role in Mental Health. Hippocrates stated that, in medicine, cure is rare, healing is sometimes and consolation is often. The same applies nowadays. Consolation depends

on the mental and spiritual aspect of the individual. In the future, medicine is directed towards prevention more than treatment and wellbeing more than cure. The anti-spiritual bias in psychiatry has many roots, including questionable assumptions of Freudian psychoanalysis, behaviorism, and the overtly simplistic reductionism of materialists. Cultivation of spirituality provides an inexpensive and powerful way to enhance well-being, as shown in recent randomized controlled trials of spiritual treatment methods.

Well-being is not enhanced by wealth, power, or fame, despite many people acting as if such accomplishments could bring lasting satisfaction. Character development does bring about greater self-awareness and hence greater happiness. The most effective methods of intervention focus on the development of positive emotions and the character traits that underlie well-being. Humanity cannot be reduced to matter, as behaviorism or molecular psychiatry. Humanity also cannot be reduced to the dualism of body and mind, as in cognitive-behavioral approaches. Developing attitudes such as passion and humor give meaning to suffering. Fostering the development of character traits such as being self-directed, cooperative and spiritual, automatically leads to a good quality of life. Psychiatry is about 200 years old. The concept of mental illness differs in various cultures from possession of evil spirits, magic, evil eye, wrath of ancestors, lack of faith, other mystical beliefs to psychosocial, biological and molecular factors.

Mental illness in Pharaonic Egypt was recognized as heart or uterine disorders six thousand years ago. There was no stigma, as no separation between psyche and soma. Mental illness was mentioned either in heart (Eber's papyrus), there was uterus (Kahoun's papyrus). Depression, forgetfulness, thought and personality disorders, perceptual disorders were attributed to the size and color of the heart and blood vessels. Treatment was magico- religious done by priests (Incubation temple in Sakkara) where dream interpretation, sleep therapy, herbal treatment, fumigation, etc., were performed.

A BRIEF NOTE ON MENTAL ILLNESS IN THE ISLAMIC ERA (591 A.C)

Three dimensions of the concept of mental illness in Islam were manifest: Possession (darkness period), innovations and expansion of the self and thirdly disharmony or constriction of consciousness (enlightened period). The word "majnoon" i.e. mad is originally derived from the word "jinn" which in Arabic overlaps with different connotations and can refer to a shelter, screen, shield, paradise, embryo and madness. In Islam, the "jinn" is not necessarily a demon. i.e. an evil spirit. It is a supernatural spirit lower than the angels that can be good or bad. That is why torture of mental patients was never practiced in Islam. The first Mental Hospital to be built in the world was in Baghdad in 705 A.D., Cairo (800 A.D.), Damascus and Allepo (1270A.D.). The 14th century Kalawoun Hospital in Cairo is extremely interesting in regard to psychiatric care. It had four separate sections for surgical, medical, ophthalmological, and mental diseases. Two features are striking: First the care of mental patients in a general hospital, which anticipated modern trends by approximately six centuries. Second the involvement of the community in the welfare of the patients.
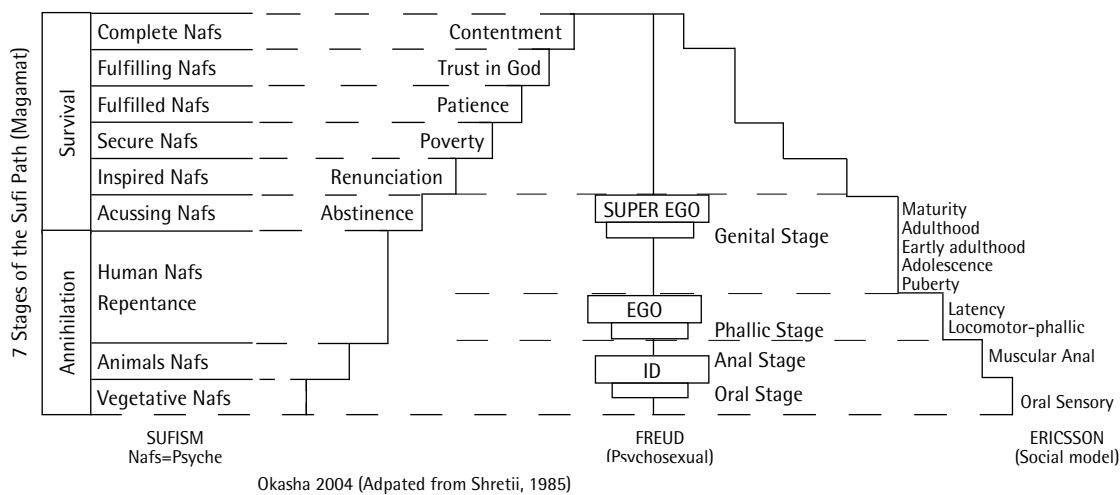

Okasha 2004 (Adpated from Shretii, 1985)

| Figure | Comparison of Stages of Human Development in islami SUFI PATH versu Freud and Ericsson |

Table 1	Common Themes of Obsessions in Egypt, India, England, Jerusalem & USA[7]					
Country	No.	Religious	Contamination	Aggressive	Orderliness	Sexual
EGYPT	90	60	41	53	47	60
INDIA	82	46	29	27	10	11
ENGLAND	45	38	23	11	9	0
JERUSALEM	10	40	20	10	10	50
USA	200	45	28	49	26	10

The following figure explains the expansion of the self or in Arabic, *Nafs* meaning the psyche and it goes far beyond the Freudian psychoanalysis or Erikson personality development.[1]

The first mental hospitals built in Europe were through the Arab influence in Seville (1409), Saragossa and Valencia (1410), Barcelona (1412), Toledo (1483) and from there, mental hospitals started in Europe.

OCD AND RELIGION

Egyptians were believers for about 6000 years. Prevalence of Obsessive compulsive symptoms in non consulting Egyptian adolescents was 43%, while obsessive traits 26%. Obsessive compulsive symptoms in different psychiatric disorders, 83%, in neurotic, stress related, 51% mood disorders, 47% with psychotics.[2]

The role of religious upbringing has been evident in the phenomenology of obsessive compulsive disorder in Islamic countries. The psychosociocultural factors are so varied that they can affect the onset, phenomenology, outcome and response to treatment of OCD. The emphasis on religious rituals and the warding-off of blasphemous thoughts through religious phrases could explain the high prevalence of religious obsessions and repeating compulsions among our Moslem sample. This is true even if the participants in the study were not practicing their religious duties. To elaborate further Moslems, who constitute almost 90% of the Egyptian population, are required to pray five times a day. Each prayer is preceded with a ritualistic cleansing process *(Wudu* or ablution), which involves washing several parts of the body in a specific order, each three times. This ablution is invalidated by any form of excretion or ejaculation and, for some radical Moslems, by any contact with the opposite sex. Women are not allowed to pray or touch the Koran during their menstruation, after which they should clean their bodies through a ritualistic bath. The prayers themselves vary in length and consist of certain phrases and *suras* from the Holy Koran that have to be read in a certain sequence.

The emphasis on cleanliness or ritual purity is the cornerstone of most of the compulsive rituals. The number of prayers and their verbal content can be the subject of scrupulousness, checking and repetition. The ritualistic cleansing procedures can also be a source of obsessions and compulsions about religious purity. Other evidence of the religious connotation inherent in obsessive compulsive disorder in Moslem culture lies in the term *weswas*. This term is used in reference to the devil and, at the same time, is used as the name for obsessions.

It is also characteristic of a conservative society like Egypt to expect sexual obsessions to be among the most frequent in female patient. Although it is accepted socially (but prohibited religiously) for Egyptian males to have a wide range of sexual freedom in all stages of their lives, sexual matters remain an issue of prohibition, sin, impurity, and shame for Egyptian women. The female gender is surrounded by so many religious and sexual taboos that the issue becomes a rich pool for worries, ruminations and cleansing compulsions in women susceptible to developing obsessive compulsive disorder.

A comparison was also drawn between the most prevalent symptoms in our sample and those of other studies performed in India, England , Jerusalem and USA. (Table II). Contamination obsessions were the most frequent in all studies. However, the similarities of the contents of obsessions between Moslems and Jews, as compared with Hindus and Christians, signify the role played by cultural and religious factors in the presentation of obsessive compulsive disorder. The obsessional contents of the samples from Egypt and Jerusalem were similar, dealing mainly with matters of religion, cleanliness and dirt. Common themes between the Indian, USA and British samples, on the other hand, were mostly related to orderliness and aggressive issue.[3-6]

The relation of Man, Nature and God is complex. Life is seen as an evolutionary continuum. Man is at the same time a part of nature and God's heir and substitute on earth. Nothing exists that is unrelated to other existing creatures. Nothing can be understood in isolation. Understanding can only be gained by examining the Undivided Whole, that is, parts plus their interaction. The Moslem Philosopher Al-Rumi

symbolic stories come to mind. It is the famous story of the people who were touching an elephant in the dark, each thinking of something, according to the part of the body they had touched. They were in the darkness of their reduced perception and missing the whole. This is a clear example of the depth of holistic approach taken by Rumi and other mystic thinkers.[8] Reviewing 4 major psychiatric journals for 5 years, only 3% of articles contained religious variables. Only 27% of psychiatrists have religious affiliation. Only 23% believe in God. However 92% may concern themselves with the religious aspect of their patients.[9, 10] Christianity, Islam, Judaism, Buddhism, Hinduism, Taoism, Confucianism all promote revolt against materialism, tolerance, mercy, virtue and justice.

Positive aspects of R/S are a modifying role in our mental life, cultivate one's own integrity, reinforce internal courage, promote responsibility, provide meaning for individual or group protective, a factor for vulnerability to depression.[11, 12] There are Negative Aspects of R/S namely it justifies dependency, facilities acceptance of individual's deficiencies, allows extension beyond the limited individual boundary, religious fundamentalism, alienation and prejudice.

THE CONCEPT OF MENTAL ILLNESS IN ISLAMIC SOCIETIES

Moslems attribute all events in life to God's will and it can be understood that the concept of mental illness can be influenced by cultural and religious aspects. For example, negative symptoms can be attributed, in some sectors of Moslem societies, to deeper contemplation about God i.e. virtuous and pious, to the extent that avolition, anhedonia, indifference and blunting of the effect of secondary psychiatric disorders, can be considered desirable social traits in certain religious cults, and so these conditions can be missed. Again positive symptoms can be attributed as gifted from God by extraordinary perception i.e. a special person. There may be religious interpretations to personality disorders e.g. schizotypal can be explained as being close to God, schizoid as a kind person, paranoid as careful, avoidant as religious and anankastic as meticulous in following religious rituals.

RELIGION, SPIRITUALITY AND MENTAL HEALTH

Religion can provide a source of explanation and understanding of questions such as the meaning of life and death. Many authors, including Frankl[13, 14] have emphasized the importance of searching for life's meaning. Frankl commented on the despair of those living in an 'existential vacuum'. He believed that frantic efforts to combat boredom and a sense of emptiness through sexual

encounters and other means are futile. Religion has an important role in social integration and control. Religion is part of the culture or way of life of a society, and it helps to maintain cultural traditions. Society can only survive if people share some common beliefs about right and wrong behavior. Durkheim[15] saw religion as a kind of social glue, binding society together and integrating individuals into it by encouraging them to accept basic social values. So, it is mainly through religion that an individual is socialized into the values of society. This set of moral beliefs and values may have been so deeply ingrained through socialization that it may have an effect on the everyday behavior of believers and non-believers alike. If some rule is broken, most individuals will experience a guilty conscience about doing something 'wrong', and this is a powerful socializing and controlling influence over the individual. Another important sociological function of religion is social support. Religious doctrines encourage positive social attitudes and self-sacrifice. Studies have shown that religiosity is strongly related to almost every dimension of social support. In the United States of America, one study confirmed that support for the elderly from church members exceeds that from all other sources combined. In Muslim countries, the mosque plays a pivot role for social cohesion, support and emotional interaction. Social support in turn is related to lower rates of depression, anxiety, loneliness, and other mental health problems. Indeed, emotional support from others is a major therapeutic tool used in all forms of counseling and psychotherapy.[16]

During the past half-century, especially the last 20 years, a number of well-designed studies have examined the relationship between mental health and religious belief, commitment or practice. The following is a review of the relationship between the use of religion as a coping behavior and depression in a sample of almost 1000 hospitalized medically ill men. People who used religion as a coping behavior were compared with those who said they coped in other ways (staying busy, visiting friends or family, and so forth). Patients who depended heavily on their religious faith to cope were significantly less depressed than those who did not. Two hundred and two patients were then followed up for an average of six months after they were discharged from hospital. The objective was to determine what characteristics of patients in the study would predict who later became depressed. The only characteristic that predicted lower rates of depression was **not** the level of support from family or friends, not physical health status, and not even income or education level but rather the extent to which patients relied on their religious faith to cope. This was the only factor that predicted significantly better mental health six months later.

Although health professionals seem to be less interested in positive states of mind than in mental disorders, several studies reported positive association between religious

Table 2	
Traditional society	**Western society**
Family and group oriented	Individual oriented
Extended family (not so geographical as before, but conceptual)	Nuclear family
Status determined by age and position in the family, care of elderly	Status achieved by own efforts
Relationship between kin obligatory	Determined by individual choice
Arranged marriages with an element of choice dependent on interfamilial relationship	Choice of marital partner, determined by interpersonal relationship
Extensive knowledge of distant relatives	Restricted to only close relatives
Decision making dependent on the family	Autonomy of individual
Locus of control external	Locus of control internal
Respect and holiness of the decision of the physician	Doubt in doctor- patient relationship
Rarely malpractice suing	Common
Deference is God's will	Self determined
Doctor - patient relationship is still healthy	Mistrust
Individual can be replaced. The family should continue and the pride is in the family ties	Irreplaceable, self pride

commitment and well-being among persons of all ages.[17-21] Other investigators have also found a positive association between religion and happiness.[22-24] Satisfaction with life is thought to be a cognitive aspect of happiness. Examining a national sample of black Americans, Jeffrey Levin and colleagues[25] found that persons who were more religiously involved experienced significantly greater life satisfaction, even after taking into account the effects of physical health status and other conventional predictors of well-being.

Islam, in its true sense, is not simply a religion but is also a way of life and gives a number of directions about leading life and sorting out the day-to-day problems. There are five pillars of Islam i.e., faith in oneness of Allah and prophet Muhammed being the last prophet, prayers five times a day, fasting in the month of Ramadam, Zakat (Alms) and Pilgrimage to Mecca at least once in a life time if one can afford it. These are the basic pillars and every Muslim has to believe and practice on these principles. In addition to the pillars of Islam, the Code of Conduct to lead day-to-day life has been explained in the religion with some approvals and disapprovals.

The role of Islamic in coping behavior can be expressed by what happened in Tsunami in Indonesia. Hundreds of children lost their parents in Achte in Indonesia and the WHO sent experts to deal with Post Traumatic Stress Disorder (PTSD). However, because of their resilience and their coping behavior following their fundamentalist Islamic upbringing that everything was attributed to God's will, there was no PTSD. Some experts stated that PTSD is a Western diagnosis as in some Islamic culture it is rather infrequent!![26]

Can religion be used in preventing Suicide? Suicide as a leading cause of death is No. 7 in Europe, 8th

Western pacific, 16th SEAR and 25th in EMRO (All Moslems) Suicide rates 3 fold higher for Jews than Arabs 9.8 Vs. 2.9 in Israel. In Malaysia, Moslems are the least in suicide with Christians and Buddhists. WHO states that religion and spirituality plays a pivotal role in suicide prevention.[28]

We need special training in religion and spirituality in psychiatry. Different modules regarding knowledge, skills in interviewing, listening, differentiating between normative religion and spirituality experience from pathological phenomena, and, lastly attitude.

We should remember that Mental health providers in developed countries are increasingly treating patients whose backgrounds are different from their own. It is, therefore, important to understand cultural belief systems including religious thought and practice that relate to mental health and illness.

Whereas spirituality and religion have often been neglected in clinical and academic psychiatry, they are increasingly recognised as being of importance in the understanding of psychiatric disorders, and in the clinical assessment and treatment of patients. Both terms lack a

universally agreed definition. Spirituality is a distinctive, potentially creative, and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately "inner", immanent and personal, within the self and others, and/or as a relationship with that which is wholly "other", transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values.

Religion is usually defined more in terms of systems of beliefs and practices related to the sacred or divine, and definitions often refer to social institutions and communities within which such systems are agreed and held in common. However, the scope and variability of such definitions is enormous, with some people identifying spirituality and religion as virtually synonymous, or at least as overlapping concepts, whilst others see them as contrasting or opposed categories. Others would see religion as much more individual than social, and yet others would focus less on religion as being concerned with belief systems and more on its concerns with morality, praxis or faith. Spiritual and religious considerations also have important ethical implications for the clinical practice of psychiatry.

World psychiatric association section on religion, spirituality and psychiatry produced a positional statement affirming that: Spiritual well-being is an important aspect of health, empirical evidence reveals a largely positive relationship between religiosity/spirituality and different indices of health.

However, religious and spiritual beliefs are powerful forces and may impart harmful as well as beneficial effects, a tactful consideration of patients' religious beliefs and spirituality should be considered as an essential component of psychiatric history taking, an understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development. There is a need for more research on both religion and spirituality in psychiatry, psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and of the families and careers of their patients, and not to use their professional position for proselytising or undermining faith. Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, in support of the well-being of their patients, and should encourage all colleagues in mental health work to do likewise. Psychiatrists should demonstrate awareness, respect and sensitivity to the important part that spirituality and religion play for many staff and volunteers in forming a vocation to work in the field of mental health care. Psychiatrists should, whenever appropriate, work for a better understanding between colleagues and patients of different religions and cultures, bearing in mind that social harmony contributes to mental health and well-being.

CONCLUSION

There is some evidence that R/S can influence the presentation, management and outcome of mental illness. Its influence on mental health requires training psychiatrists of how to approach the issue of R/C.

There are few questions to be answered for future studies in the field of religion and spirituality and mental health:

11. What is the association between religious affiliation and distribution of psychiatric disorders in the general population?
12. What is the association between religious affiliation and use of mental health services by the general population?
13. What religious beliefs and practices are most common among persons with good mental health?
14. How might healthy components of religion be integrated into psychotherapy with religious patients?
15. How might community mental health agencies, social services, and religious organizations best work together?
16. What is the best way to educate psychiatric professionals about the contributions that R/S can make to patient care?[29]

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