

Clinical Implications of Research on Religion, Spirituality, and Mental Health

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The relation between religion and (or) spirituality (RS), and mental health has shown generally positive associations; however, it is a complex and often emotion-laden field of study. We attempt to examine potential mechanisms that have been proposed as mediators for the RS and mental health relation. We also examine more philosophical areas including patient and physician opinions about inclusion of RS in patient care, and ethical issues that may arise. We review suggested guidelines for sensitive patient inquiry, and opportunities and challenges for education of psychiatrists and trainees. We also study practical ways to incorporate psychospiritual interventions into patient treatment, with specific reference to more common spiritual issues such as forgiveness, gratitude, and altruism.

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Clinical Implications

- RS may impact mental health through multiple dimensions including the biological, psychological, and social realms.
- Mental illness is a time when personal resources are challenged and RS may be a clinically significant positive or negative source of coping.
- Education about RS and mental health will inform clinicians about ways of inquiry, potential issues to address, and ethics of the interaction.

Limitations

- There is limited research into practical psychospiritual interventions in psychiatrically ill populations.
- The research has just begun to examine the complexity of proposed mechanisms from a multidimensional perspective.
- Measures of RS are often assessed in ways that may blur differences that exist between faith traditions.

Key Words: religion, spirituality, mechanisms, ethics, education, clinical implications

In general, research has shown RS positively affects mental health outcomes, as noted by Koenig.¹ Although largely reporting on US studies, an increasing body of literature on the effects of spirituality on mental health from numerous countries, including Canada,^{2–6} indicates the findings apply across boundaries and religions.

However, the literature is dominated by a spirituality that finds its expression through religious observance. From a practical perspective, this raises the question of the clinical relevance of these findings for people who are not necessarily

religiously observant. The relevance could be demonstrated by an exploration of the putative mechanisms through which spirituality may exert its affect. This perspective is important for a population such as Canada's, where, during the last decades, the percentage of Canadians who report regular church attendance has decreased dramatically.⁷ Fifty years ago, Canada had a larger proportion of its population attending religious services than the United States; this proportion has since noticeably dropped, positioning Canada about halfway between the United States and European countries.⁷

Two major trends are apparent. First, a smaller percentage of Canadians attended religious services at least monthly in 2004, compared with 1985 (32% and 41%, respectively).⁸ Second, according to 2001 census data,⁹ the proportion of the population identifying with a religion other than Christianity is increasing, largely owing to immigration, while the proportion of the population classified as Catholic or Protestant decreased from the previous decade. Statistics of religious affiliation alone do not tell the whole story. Bibby's research¹⁰ on the sociology of religion in Canada suggests a modest upswing in the number of people adhering to some of the faith communities, while the number of nominally religiously adherent people is decreasing. Further, while a person may not affiliate with a faith community, they may still identify with a church for certain religious rituals (for example, weddings and funerals).

Canada's policy of multiculturalism (diversity) may possibly contribute to the increase in the number of people who identify themselves as spiritual but not religious. It is quintessentially Canadian to search for common ground and therefore to seek what disparate ethnic or religious groups may have in common, thus emphasizing a spirituality that is not bound specifically to a particular religion.

Given the importance of this discussion for a broader context than religious observance and practice, and in light of the review examining research in mental health,¹ this paper will focus on the clinical implications of this research to the psychiatrist and patient.

Mechanisms Mediating Outcomes of RS Practice in Mental Health

Research considering religion, spirituality, and health (physical or mental) comes from diverse fields including cognitive and social psychology, neuroscience, epidemiology, and medicine. This has led to widely varying models of religion's influence on health—health behaviours, social support, psychological states, superempirical or psi states¹¹—reflecting that the different pathways by which RS may influence health are likely multilevelled.¹² Mechanisms working at one level (for example, the psychological) do not preclude mechanisms working at other levels (for example, the biological or social),¹³ leading some to conclude that the power of spirituality may lie in the fact that it is “fully embedded in the fabric of

life.”^{14, p.21} The challenge for research has been to move from simply describing a relation to exploring factors that may underlie this association.

Social

The social domain was one of the first areas explored for mediators of the religion–health association. In this domain, environmental influences such as health behaviours, group connectedness, and social resources have been primarily studied as mechanisms through which religion may influence health and (or) mental health.^{15–18} Examples of religion-based influences on health behaviours include proscriptions regarding the excess use of nicotine, alcohol, or drugs of abuse, and in some cases prescriptions about diet. Substance dependence and abuse have high comorbidity with many psychiatric disorders but correlate negatively with RS measures,^{2,19} particularly in the context of a supportive and nurturing belief system.²⁰ Religious service attendance is positively associated with other positive health behaviours including use of preventive health care, enhanced physical activity, and fewer risk-taking activities^{21,22}; the relation with obesity remains uncertain, with some studies indicating obesity is positively associated with religiosity.²³

Social support is another plausible mechanism by which religion may affect mental health. Some components of religiousness, such as religious service attendance and religious coping, have been linked cross-sectionally and longitudinally to lower depressive symptoms as well as higher social support.²⁴ However, data concerning social support as a mediator in this religion–depression relation are not conclusive,^{15,25,26} and thus religiousness may influence depression through additional pathways.²⁷ Social support may indirectly mediate this relation along with other forms of psychological and social activity, such as optimism and volunteering.²⁸ Teasing apart positive and negative church-based social interactions has also demonstrated differential and significant effects on depressive symptoms.²⁹ Positive interactions are associated with fewer depressive symptoms and negative interactions are associated with higher levels of depressive symptoms.

Psychological

Allport and Ross³⁰ first attempted to discriminate among people according to their cognitive religious content and the degree to which religious values were applied to their lives. They proposed the concept of extrinsic and intrinsic religious orientation. People with an extrinsic orientation are disposed to use religion for their own ends (that is, security, solace, sociability, distraction, status, and self-justification). People with an intrinsic orientation find their reason for being in their religious beliefs.³¹ A meta-analytical review of religiousness and depression demonstrates a clear contrast

Abbreviations used in this article

MDD	major depressive disorder
PFC	prefrontal cortex
PTSD	posttraumatic stress disorder
RS	religion and (or) spirituality

where intrinsic religious motivation is associated with lower depression and extrinsic religion motivation with higher depression.³²

In a review of cognitive-behavioural mechanisms that may underlie the association between RS and mental health, James and Wells³³ propose that religious beliefs (schema) provide a mental model for guiding appraisal of life events and are important in self-regulation of thinking processes. They note religious attributions for life events may provide a sense of meaning, perceived control, and predictability, particularly in times of high stress. This sense of meaning may help to reframe trials as a spiritual opportunity, a wake-up call, or even punishment.^{34,35} Interestingly, the strength of one's belief position (whether it be no faith or strongly religious) may be an important indicator of lower distress, compared with a weaker belief system (that is, extrinsic religiousness) that may not be able to respond to the types of questions raised by significant stressors. Religious behaviours that contribute to self-regulation by reducing self-focus and worry while providing a calming effect (for example, contemplative prayer, mindfulness meditation, and religious rites) are positively associated with mental health.^{33,36} Religiously motivated behaviours that increase self-focus and worry are associated with intrusive thoughts, thought control and undoing, and poorer mental health.^{37,38}

Understanding the role of RS in coping with mental health issues is also a significant field of psychological study. As a leader in this field, Pargament³⁹ has developed positive and negative religious coping measures that reflect various coping styles, such as self-directing, collaborative, deferring, and surrender. He summarizes the findings in this body of research by noting that better mental health has been linked positively to a religion that is internalized, intrinsically motivated, and based on a secure relationship with God and negatively to a religion that is imposed, unexamined, and reflective of a tenuous relationship with God and the world.³⁵ This statement underscores the complexity of RS coping, which includes spiritual appraisal, personal factors (religious doctrine, orientation, and hope), behaviours (religious service attendance and private RS practices), and spiritual connections (nature, others, and transcendent other).³⁴ The degree to which this type of coping or cognitive schema promotes positive emotions, such as forgiveness, gratitude, optimism,⁴⁰ compassion,⁴¹ or hope, and how these pathways may impact mental health⁴²⁻⁴⁴ are reviewed in a later section.

Biological

An emerging field known as neurotheology explores the relation between spirituality, spiritual experiences, and neurological processes.⁴⁵ In classic neuroimaging studies (single photon emission computerized tomography) of Buddhist

monks and Franciscan nuns meditating or in prayer, Newberg et al⁴⁶ show increased blood flow in the frontal lobes (possibly representing increased focus), cingulate gyri, and thalami, and decreased blood flow in the superior parietal cortices (possibly representing loss of physical representation of self).¹² Muramoto⁴⁷ hypothesizes religious activity is particularly localized in the PFC, which is involved with error detection, monitoring, and compliance with social norms. A healthily functioning PFC would be represented by compliance to norms, empathy, and compassion; a hyperfunctioning PFC would be characterized by rigid conformity and perhaps a delusional interpretation of God's mind; a hypofunctioning PFC would imply reckless lack of self-control and apathy. However, this field of study is not without detractors. Sloan⁴⁸ has questioned the value of this research as it either implies something special in the religious experience, owing to its neurophysiological underpinnings, or it simply shows areas of the brain that are active in a particular activity, neither of which he feels advance the understanding of the field in a meaningful way.

Physiological variables such as neurohormonal, neuroimmunologic, or cardiovascular functioning are also explored as potential mediators. In a computer task-induced stressor, religiosity was associated with lower cortisol reactivity in undergraduate students and in males with lower blood pressure.⁴⁹ In HIV-positive men and women, spirituality was associated with higher positive reappraisal coping scores and greater benefit finding, which were in turn both related to lower depressive symptoms. Spirituality was also related to lower urinary cortisol through positive benefit finding.⁵⁰

This possible attenuation of the stress response has significant implications for both physical and mental health. Associations between religious activities and lower blood pressure⁵¹ as well as better immune functioning⁵² are also reported. In contrast, no association was found between RS (Taoist and Buddhist) and biological markers (interleukin-6, blood pressure, and urinary cortisol) after controlling for health status in a large sample of elderly Taiwanese people; the study⁵³ concluded that social participation had a more robust effect. Differentiating what is truly an RS intervention or effect from a more general social response remains a challenge in measurement and a focus of criticism of this line of research.

A more comprehensive measure of overall physiological state may provide even further useful information in understanding the role RS may play in mental and physical health.⁵⁴ Physiological biomarkers capture dysregulation in the cardiovascular system, hypothalamo-pituitary-adrenal axis, sympathetic system, and metabolic processes, and refer to the body's stress response. Stress promotes adaptation in

body systems in the short term but prolonged stress leads, over time, to wear and tear on the body. This condition, or allostatic load,⁵⁵ leads to impaired immunity, atherosclerosis, obesity, and atrophy of nerve cells in the brain. Many of these processes are seen in psychiatric disorders.^{56,57} Spiritual, religious, and other factors that enhance coping, decrease physical or emotional stress, decrease risk-taking behaviours, or enhance positive health behaviours may be protective factors against the chronic wear and tear on the body systems.⁵⁸ Cognitive factors such as a sense of coherence⁵⁹ or other factors such as social relationships⁶⁰ are protective regarding allostatic load and may be associated with religious activity.⁶¹ Maselko et al⁵⁴ analyzed data from the McArthur Study of Aging to determine the relation between allostatic load and religious service attendance, and any mediative effect of social networks. While no effect was found for males, allostatic load was significantly lower for females, with high worship frequency independent of social networks.

Genetic

Genetic studies have begun to inform the RS and mental health field. Kendler et al⁶² found a strong environmental role for similar familial RS beliefs and practices but also found genetic factors accounted for 29% of the variance of personal devotion (a composite of salience of religious beliefs, church attendance, private prayer, and seeking spiritual comfort). Personal devotion was also an important factor in lowering the risk for substance use and dependence, and protected against the depressogenic effects of major personal stressors.⁶³ Analysis of the Dutch Twin Registry found different aspects of religion were entirely explained by environmental factors with the exception of the personality factor disinhibition. Receiving a religious upbringing seemed to reduce the influence of genetic factors on disinhibition, particularly in males⁶⁴; however, similar to a study from the Virginia Twin Registry,⁶⁵ very little contribution to other personality traits was noted.

Practical Implications

Given the burgeoning research in the area of the biological and psychological mechanisms relating to the health benefits of RS, we now turn our attention to the practical implications of the relation between RS and mental health. We will attempt to answer the question of whether any empirically based approaches are open to patients who wish help of a spiritual nature. In including these topics in our review, we make no claim that these emotions or states are the sole purview of either religion or spirituality. They are included because they are teachings held in common by major religions and many other spiritual systems as one of the outcomes of spiritual practice.

During the past 2 decades, researchers have discovered that positive acts and emotions have a profound effect on health. Funding became available for research in positive psychology, both from conventional grantors and from institutes such as the Templeton-funded Institute for Research on Unlimited Love. Consequently, research has been undertaken in fields such as altruistic love, forgiveness, and gratitude—all traits found in both religious and spiritual teachings. Below, we address selected research on these psychospiritual states but note much has been undertaken by academic psychologists and may not be immediately applicable to practice.

Altruism

Altruistic behaviour is defined as the degree of obligation felt in situations involving helping others at one's personal expense.⁶⁶ In a large, stratified, random sample ($n = 2016$) of members of the Presbyterian Church throughout the United States, giving help was associated with better mental health, compared with receiving help.⁶⁷ This is consistent with the benefits of self-initiated volunteerism on mental health.⁶⁸ In adolescence, generative behaviour—of which altruism is a major component—can predict being peaceful, happy, calm, and in better health in old age.⁶⁹ Altruistic behaviour in older age augments well-being and life satisfaction.⁷⁰

There is a limit to the amount of time that can be spent in volunteer altruistic activities, and exceeding this limit can adversely impact health.⁶⁷ While evidence indicates helping others promotes mental health, almost no research explores the effects of altruistic behaviour on mental disorders. We found only one paper⁷¹ examining the role of altruistic behaviour in generalized anxiety disorder and MDD in a broadly defined middle-aged population (aged 25 to 74 years), part of the National Survey of Midlife Development in the United States. This study noted a small beneficial effect of altruistic behaviour on subjects with anxiety disorders and a significant negative effect in patients with MDD. Notably, this cross-sectional study measured altruism by responses to hypothetical questions and not to actual behaviours.

Gratitude

The grateful disposition has been demonstrated to be a discrete emotional experience and an affective trait that can be differentiated in 3 distinct domains: emotionality—well-being, pro-social behaviour, and spirituality—religiousness.⁷² Further, gratitude is inversely related to neuroticism.⁷³ Grateful moods are generated by influences of the more stable personality traits, and also from experienced daily events.⁷³ Some people are evidently more prone to be grateful, while others respond more to the events of the day; both contribute to mood.

Focusing on gratitude can improve well-being even in people who are chronically ill. Social psychology studies have demonstrated being dominated by negative emotions as a reaction to an acute stressor is a temporary state. We adapt, and our natural traits gradually assert themselves, and moods of happiness and gratitude can become apparent.⁷⁴ Gratitude improves one's sense of well-being; significant increases in positive affect, life satisfaction, and subjective well-being were noted in subjects (both in students and in neuromuscular patients) who kept a gratitude diary each day, compared with those who reported their irritations.⁷⁵ We did not locate any studies replicating these findings in people suffering from psychiatric illnesses such as depression or anxiety.

Forgiveness

Many definitions of forgiveness exist but all seem to agree it is a positive method of coping with an offence that causes the victim to deal with the negative emotions, thoughts, and actions directed at the offender.⁷⁶ Therefore, forgiveness is a reduction in unforgiveness and the promotion of more positive understanding and regard for the offender. This definition of forgiveness does not include expectations of releasing the offender from responsibility, ignore or minimize the offence, and demand reconciliation.

Unforgiveness has been associated with negative emotional and physical effects. Unforgiving thoughts engender more adverse emotions indicative of stress as measured by electromyogram of the corrugator muscle, skin conductance levels, heart rate, and mean arterial pressures, as compared with a forgiving response group⁷⁷; we postulate these emotional and physiological responses experienced chronically represent a stress that can affect the functioning of the immune system. Chronic stressors, including the stress of mental illnesses, are part of the burden of stress leading to health consequences.⁷⁸ For example, chronic hostility in couples is associated with differences in wound healing and inflammatory cytokine production, compared with couples with more positive interactions.⁷⁹

Numerous studies indicate the positive effect of forgiveness on self-rated health,⁴³ hypertension,⁸⁰ chronic pain,^{81,82} addictions,⁸³ and PTSD.⁸⁴ Data from the Truth and Reconciliation Commission in South Africa⁸⁵ indicate depression, PTSD, and other psychiatric disorders are significantly higher among people who demonstrate less forgiveness years after the events.

Various psychoeducational and psychotherapeutic forgiveness interventions have been developed and evaluated, and are summarized in 3 recent reviews.^{76,86,87} A meta-analysis by Baskin and Enright⁸⁶ of 9 forgiveness outcome studies found them grouped into 3 separate models. The first model was based in individual therapy and the second model focused on

the process of forgiveness in groups; the time commitment for both models was considerable. The third grouping was a brief, decision-to-forgive-based model. The findings indicate process-based forgiveness therapy was more effective than decision-based therapy, individual counselling was more effective than group-based counselling, and the process model in particular proved to be effective. Therapies of longer duration were found to be more effective, in keeping with the process model.

Wade and Worthington⁷⁶ analyzed 14 studies for the common core of forgiveness interventions. Most of the approaches spent time defining forgiveness, recalling the hurt, then emphasized building empathy for the offender as part of common humanity. These studies also helped people engage in the delicate task of acknowledging their own offences. People are helped to commit to forgiveness, recognizing the necessity to reduce unforgiveness, either through discussion or cognitive reframing.

In a more recent study, Harris et al⁸⁸ devised a 6-week group-based forgiveness training program using a combination of psychoeducation, cognitive restructuring, positive and negative visualizations, and heart-focused meditation techniques. The randomized control study ($n = 259$, enrolled; $n = 134$, in treatment group) focused on event-specific forgiveness, forgiveness likelihood in new situations, and psychosocial outcomes related to health, with ratings obtained at 6 weeks and 4 months. The program was 2 to 3 times more effective in reducing negative thoughts about the target transgression than the control group, and produced significant increases in positive thoughts, forgiveness self-efficacy, and forgiveness in new situations. Significant decreases in anger and stress were also noted. In short, forgiveness interventions seem to be useful therapeutic approaches for people requiring a forgiveness focus.

Psychiatrist–Patient Opinions Regarding RS in Clinical Practice

A 1986 systematic review of religious variables in 4 major psychiatric journals highlighted the paucity of research in RS and mental health.⁸⁹ At that time, articles appeared highlighting the disproportionate examples of religion to describe psychopathology in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised⁹⁰ that patients frequently turned to religious professionals for mental health care,⁹¹ and that there were higher levels of religious beliefs among patients than among psychiatrists.⁹² Religion became termed “the forgotten factor”^{93, p 1} in mental health. Twenty years later, and after a vast amount of research in RS and mental health, surveys still show psychiatrists remain less religious than other physicians,⁹⁴ their patients, and the general population. Notably, psychiatric^{95,96} and medical

patients⁹⁷⁻⁹⁹ still express an interest in having their spiritual needs considered. Although a shift is evident, as recent Canadian⁹⁵ and US¹⁰⁰ surveys indicate most psychiatrists now appreciate the importance of RS in mental health and appear more comfortable in discussing it with patients. The physician's own RS beliefs continue to remain the most important predictor of attitude and comfort with the topic.¹⁰¹ The awareness of psychiatrists about the research in RS and mental health is not known, although various psychiatric organizations, worldwide, are including sections on religious and spiritual interests (for example, the World Psychiatric Association; the Royal College of Psychiatrists, United Kingdom; the Center for Spirituality, Theology and Health, Duke University, United States; and, the Association of Spirituality and Mental Health, Canada.)

Psychiatric Education Dealing With RS Issues

The interest in the interface between RS and psychiatry has resulted in initiatives to include the topic in psychiatric education.^{102,103} Reasons to integrate RS in psychiatric training are numerous. Patients consistently express the preference for consideration of RS issues in their care.^{99,104,105} A survey of Canadian psychiatric patients indicates 53% would welcome inquiry about RS in their mental health care.⁹⁵ Patient-centred, whole-person care is desired by patients for whom spirituality is a part of their care.⁹⁵ In addition, the large body of empirical research on RS and mental health is an important addition to overall learning. Accreditation standards for medical schools, as defined by the Liaison Committee on Medical Education in conjunction with the Committee on Accreditation of Canadian Medical Schools,¹⁰⁷ and for postgraduate programs, through the Royal College of Physicians and Surgeons of Canada (Canadian Medical Educational Directions for Specialists),¹⁰⁸ now require competency in understanding ways in "which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments."^{107, p 9}

The focus is on being able to communicate effectively, including dialogue about religious and spiritual values, understanding one's personal perspective during treatment, and being able to demonstrate ethical human values in understanding the patient's cultural and spiritual context. The John Templeton Foundation in conjunction with the George Washington Institute for Spirituality and Health has facilitated the educational component through awards to undergraduate and postgraduate Family Medicine and Psychiatry programs for curriculum design and implementation. This initiative has helped to spearhead the development of many programs in the United States. A survey of Canadian psychiatry programs found residents were receiving only minimal exposure to the interface of RS and psychiatry.¹⁰⁹

Model curricula have been described,^{102,110} including one specific to Canada.^{109,111} Time involvement ranges from many hours of teaching to short workshops, but generally includes the objectives of learning a short, respectful, and nonjudgmental spiritual needs assessment, familiarizing with spiritual care resources, and being able to justify the inclusion of spirituality by reference to current, credible research on spirituality and mental health.

Addressing Spirituality in Psychiatric Care

As research into the relation between RS and health has expanded, physicians are left to determine the ramifications (if any) to the patient encounter. Family medicine, palliative care, oncology, and internal medicine have developed principles for accommodating RS beliefs and recommendations for discussion.¹¹²⁻¹¹⁴ Short spiritual interviews, with acronyms designed to aid memory, have been suggested as part of the social history, such as FICA (Do you have a Faith or belief?, Importance in clinical care, Are you part of a faith Community?, Is there some way you would like it to be Addressed as part of care?¹¹³) and HOPE (source of Hope or meaning, Organized religion, Personal spirituality or Practices, and Effect on medical care and [or] End of life¹¹⁵). The same approaches have been encouraged within psychiatry¹¹⁶; however, caution is required depending on the degree of patient distress and psychopathology that may preclude this and often other types of inquiry.¹¹⁷

Psychotic phenomena may have a religious orientation, including delusions or distortions of normative religious beliefs, such as scrupulosity, delusions of specific deity guidance, or indeed being a deity.¹¹⁷ People with depression may have ruminations of past transgressions and lose their sense of connection with their higher power or feel eternally damned.¹¹⁸ This does not suggest all people with serious mental illness will express these forms of pathology, and sensitive inquiry in more stable people may reveal spiritual issues that hinder or help diagnosis or treatment. In a survey in Geneva of patients ($n = 100$) with a psychotic illness, only 16% had overlap between religious beliefs and psychopathology; however, others expressed a conflict between their religious beliefs and medication of which their psychiatrist was unaware.¹¹⁹ In a survey of more than 400 people with persistent mental illness in Los Angeles County, 48% indicated religion became more important to them when their symptoms worsened. Further, these 48% were less likely to be admitted to hospital in the year prior than those for whom RS became less important when symptoms worsened.¹²⁰ Therapy groups on spiritual issues for patients with chronic and severe mental illness, conducted with careful attention to group rules, have been shown to be successful ways to explore how spirituality is affected by mental illness.^{121,122}

Acknowledging the patients' explanatory framework for their illness, expanding the consultative network, and being aware of spiritual interventions may be outcomes of open spiritual inquiry.¹²³ Guidelines for evaluating if medical goals are being achieved and if the patient's values are preserved help to inform the clinician about spiritual interventions that may be sought by the patient.¹²⁴

Ethics

Research into the relation between spirituality and health raises ethical questions about the use of RS in clinical settings. Opinions on this issue range from support for an open promotion of religious observance, if it is of benefit, to statements that a person's spirituality is private and certainly not within the scope of health care practice except by chaplains as members of health care teams. The point is made that a health professional's personal RS belief system is not qualification enough to address this topic with patients. Sloan et al¹²⁵ argue the existence of 4 major areas of ethical concern. First, owing to the power differential between a physician and patient, an element of coercion can be present in matters of faith.¹²⁶ Second, they argue a person's faith or spiritual practice is inherently private and need not be revealed to a health care professional. Further, occasions may occur where harm could come from the specific religious approach; for example, promotion of the belief that if one just has enough faith, their difficulties would resolve. Finally, they argue that, in effect, advice to engage in religious observances is inherently discriminatory, as the health benefits apply only to those who believe.^{48,126}

The counter to this position is that medicine is not restricted purely to a materialistic perspective. Instead, it encompasses the biopsychosocial–spiritual model. Further, research shows many patients want to be asked about their spiritual commitments and concerns. This is important information for the physician and the health care system, and consequently RS influences should be acknowledged and incorporated into a more meaningful relationship with the patient.^{126–128} As a general rule, most research stops short of advocating increased religious observance by the patient for potential health benefits. Considering an interdisciplinary approach to spiritual issues that arise in mental health care is prudent, and referral to the chaplain who is the spiritual care expert is recommended.¹²⁹

A high percentage of the population acknowledges they pray, and indeed a recent meta-analysis shows at least equivocal evidence of the effectiveness of nonlocal prayer.¹³⁰ What then are the ethical considerations of whether a physician prays with their patients? Again, opinions range from supporting the occasional participation of a physician or health care team member in prayer at the patient's request or as a silent witness

to the patient's prayer, to deferring instead to a chaplain with training in the application of spiritual practices within the health care system. Post et al¹²⁸ summarize a well-reasoned position:

Physician[-]led prayer is acceptable only when pastoral care is not readily available, when the patient is intent on prayer with the physicians, and when the physician can pray without having to feign faith and without manipulating the patient.^{p.582}

Summary and Conclusions

There has been much research and discussion about potential mechanisms by which RS may impact mental health, suggested clinical implications and applications, along with cautions and concerns. The diversity of research and the various fields of study underscore the complexity of attempting to understand how a person's faith and beliefs relate to their illness or health. The challenge for the clinician is to synthesize this research from different orientations (that is, cognitive, social, and biological) to make it applicable to patient care. First, being aware of this dimension of a person's life is a key factor, and practical tools for sensitive inquiry have been reviewed. Second, it is important that the psychiatrist recognizes that times of mental illness are times that challenge coping resources and RS may be a positive or a negative factor in coping. For this reason, RS may benefit from meaning exploration with each person. Third, interventions that have examined volunteering, gratitude, and forgiveness show promising results in healthier populations and the evidence suggests they may be at least cautiously explored in psychiatric populations. This would be a potential area for future research.

Enhancing physicians' awareness of the literature and providing the groundwork to consider a balanced approach to RS in mental health is important in this potentially emotionally charged and polarizing field. Providing sensitive, patient-centred care involves the challenge of considering all aspects of our patients' lives, being willing to examine and understand our own biases, and working together to optimize mental health. Open dialogue, empirical research, and scrutiny by peer review remains of utmost importance.

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Résumé : Implications cliniques de la recherche sur la religion, la spiritualité et la santé mentale

La relation entre la religion et (ou) spiritualité (RS), et la santé mentale a montré des associations généralement positives; toutefois, il s'agit d'un domaine d'étude complexe et souvent chargé d'émotions. Nous tentons d'examiner les mécanismes potentiels qui ont été proposés comme médiateurs de la relation entre la RS et la santé mentale. Nous examinons également des domaines plus philosophiques, notamment les opinions des patients et des médecins sur l'inclusion de la RS dans le soin des patients, et les questions d'éthique qui peuvent être soulevées. Nous examinons les lignes directrices suggérées pour les renseignements délicats sur les patients, ainsi que les possibilités et les défis de la formation des psychiatres et résidents. Nous étudions aussi des moyens pratiques d'incorporer des interventions psychospirituelles dans le traitement des patients, en faisant référence spécifiquement à des notions spirituelles plus répandues comme le pardon, la gratitude et l'altruisme.