Religion and Mental Health - Empirical Findings in Europe

or

Religion, spirituality and mental health – what is the evidence and how does it challenge our approaches to patients?

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London, UK
May 2016

Outline

- Claims about the evidence
- Evidence on the R/S-mental health link
  - European studies
  - World research
- Evidence on religious/spiritual interventions
- What it might mean for practice?

But first…a health warning

- Psychologists of religion who have been in the field for a while can agree on one thing: we have never agreed about anything

  – Ken Pargament 1999

The claims

- Many claims for +ve association between religious belief, spirituality and health
  - Frequent neglect of the strength of this association
- Psychological, physiological, social, theological and "supra-empirical" explanations
- However, the focus has been on
  - Christian denominations
  - North American populations
  - Religious identification rather than spiritual belief
    - Relative neglect of 'spiritual' without religious affiliation or practice

Ideas

- Evidence in the US that religious and spiritual belief and practice is linked to better health outcomes
- Less evidence arises from Europe
  - Suggests important cultural factors in the findings
- It makes us think about the instruments developed and the methodological approaches

European research

- Mainly cross-sectional in nature
- Prospective research less common
  - Enables an examination of mechanisms
  - But cannot definitively indicate cause
    - But at least removes the possibility of reverse causation

    - An example of Pan European research…..

The predictD study

Study population

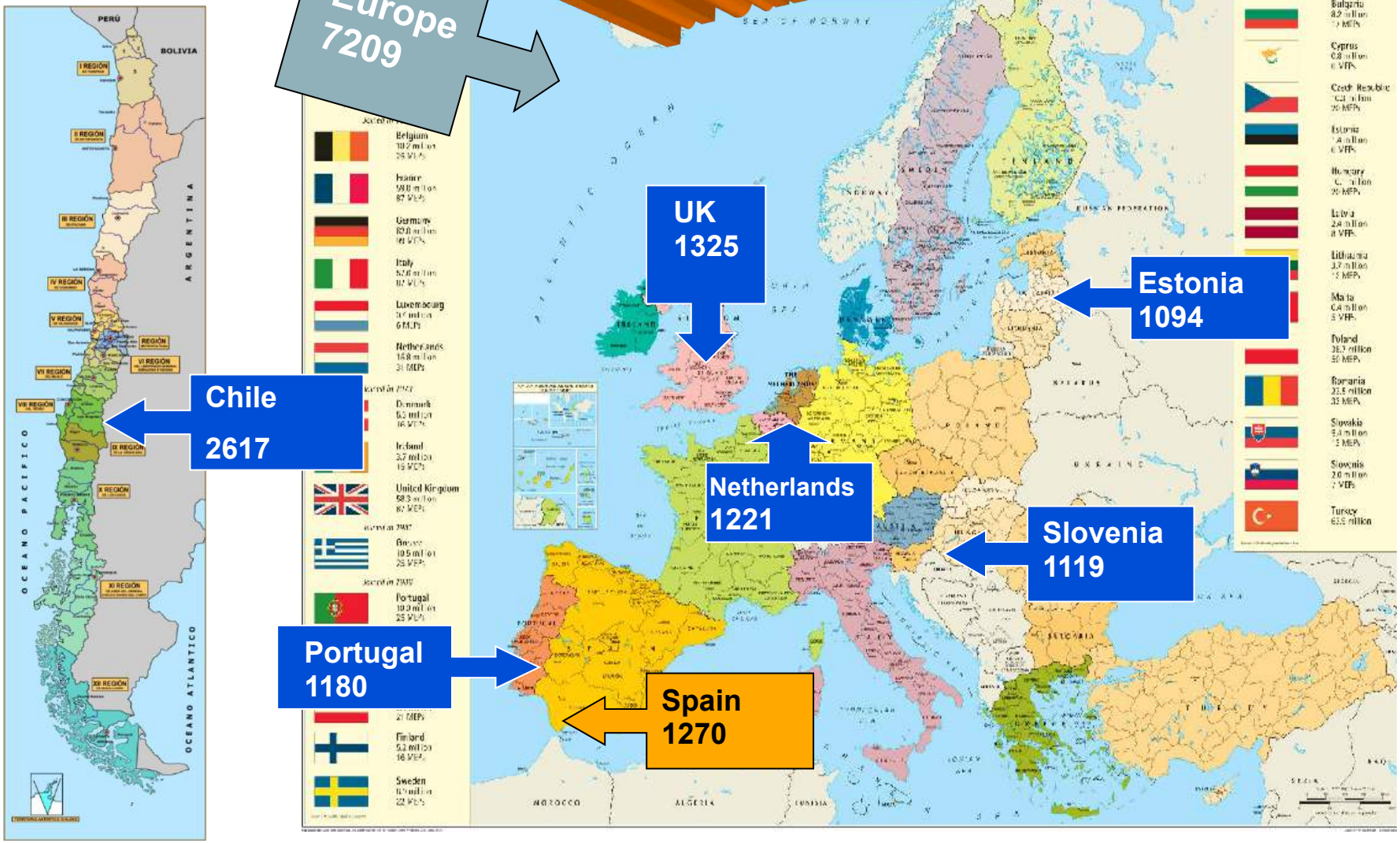
Unselected GP attenders in 6 European (and 1 Latin American country)

Main objective of the original study:

Develop and validate a multi-factor risk estimator for prediction of major depression.

Opportunity to study religion as a predictor of onset of major depression

predictD-Internacional



Opportunity to study R/S as a predictor of onset of major depression

- 8,299 not depressed at baseline
- Association between “life view” at baseline and onset of depression after 6 or 12 months
- Adjustment for country, sex, age, education, social support

First an introduction to the instrument used

- Royal Free Interview for Religious and Spiritual Beliefs
  - Attempts to distinguish religion and spirituality
  - Content, practice and strength of belief

King, Speck & Thomas *Psychological Medicine* 1995;**25**:1125-1134

Royal Free Interview for Religious and Spiritual Beliefs – starts with…

We are going to ask you some questions about your religious and spiritual beliefs. Please try to answer them even if you have little interest in religion.

In using the word *religion*, we mean the actual practice of a faith, e.g. going to a temple, mosque, church or synagogue. Some people do not follow a specific religion but do have *spiritual* beliefs or experiences. For example, they may believe that there is some power or force other than themselves that might influence their life. Some people think of this as God or gods, others do not. Some people make sense of their lives without any religious or spiritual belief.

Therefore, would you say that you have a *religious* or *spiritual* understanding of your life? (Please tick one or more).

- Religious
- Religious and spiritual
- Spiritual
- Neither religious nor spiritual

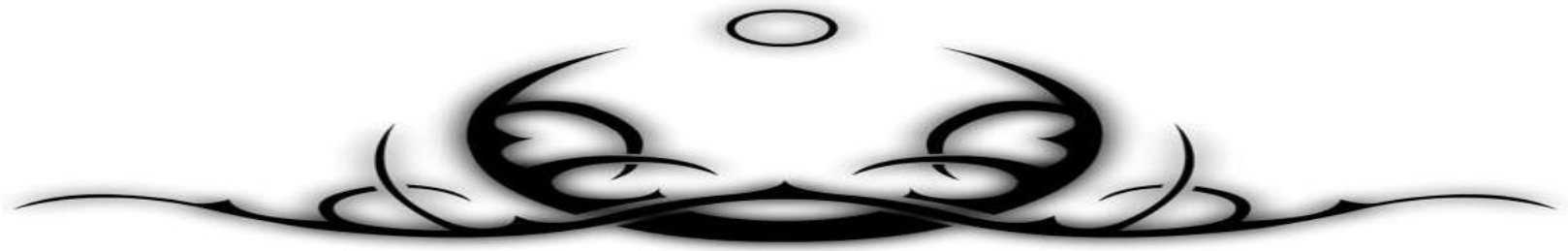
Royal Free Interview

- Religious, spiritual or other understanding of life

- ‘Spiritual scale’ - sums strength of belief and influence of the spiritual in life

We also asked about spiritual experiences

"Have you ever had an *intense experience* (unrelated to drugs or alcohol) in which you felt some deep new meaning in life, felt at one with the world or universe? (If you believe in God it may have felt like an experience of God.) It might have been for a few moments, hours or even days."



Use of “life view” – is a European perspective

- Spirituality
  - ‘Understanding of life’
  - ‘Life view’

Stifoss-Hanssen H. (1999) Religion and Spirituality: What a European Ear Hears. *International Journal for the Psychology of Religion*, 9:1, 25-33

Stifoss-Hanssen H. (1999) Religion and Spirituality: What a European Ear Hears. *International Journal for the Psychology of Religion*, 9:1, 25-33

- 'Spirituality is people's search for meaning in relation to big existential questions.'

- In contrast to Pargament, Koenig and others in USA
  - Where a sense of the 'sacred' is the common core to religion and spirituality
  - Spirituality becomes subsumed into religion

Similar to that arising from a Consensus Conference sponsored by the Archstone Foundation 2009 on spirituality in palliative care

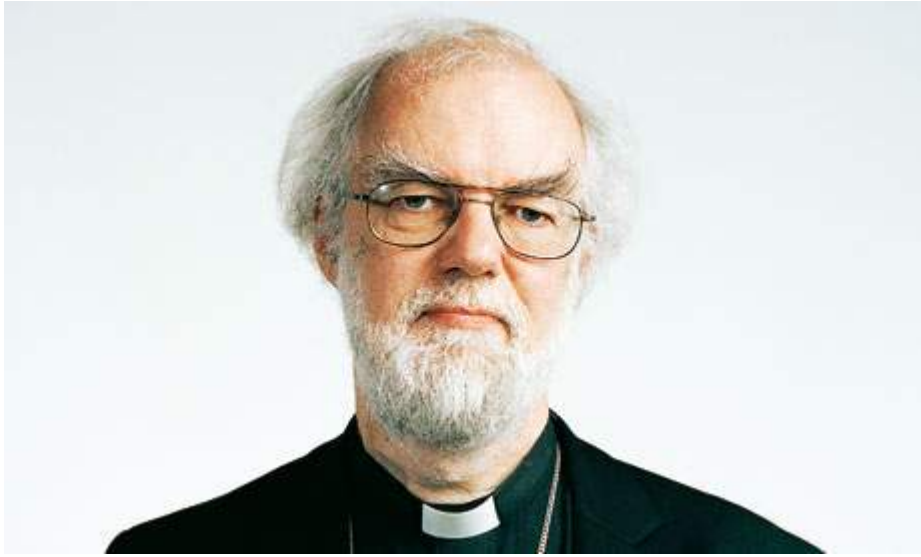
•Spirituality ….. refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to other, to nature, and to the significant or sacred

•Pulchaski et al. 2009

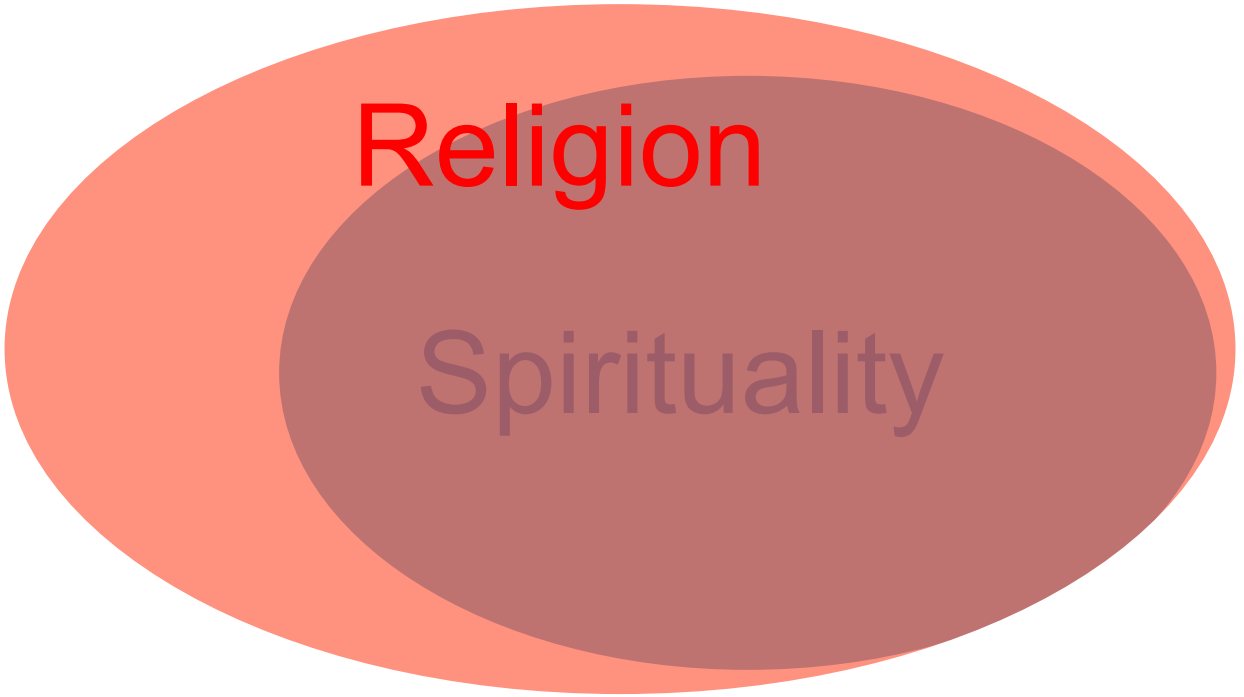
In Europe even religion morphs into something distinctly spiritual

- “Religion is not primarily about a higher power but it is more about our feeling of discomfort, of being out of joint, that this world cannot be it, that we are not at home here.”

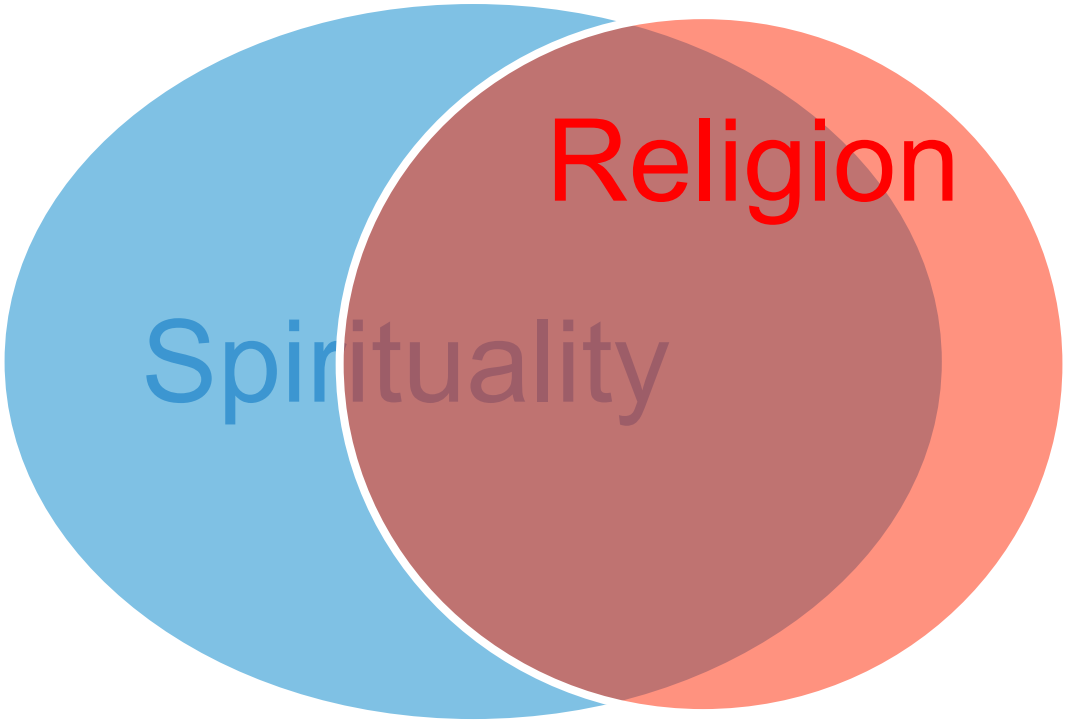
Former Archbishop of Canterbury, Rowan Williams on BBC Radio 4



USA - a search for the sacred



Europe – a search for meaning which may or may not concern the sacred



The Royal Free instrument

- No specifically theological content
  - In particular not tied to Judaeo-Christian concepts
- Measures intensity of belief and importance in person's life
- Self report or interview format is:
  - comprehensible and reliable
  - validity is complex and criterion based
  - but - forced choice loses information

- Can be found at Behavioral Measures Core
  - http://www.behavioralmc.org/InstrumentDetail.aspx?catid=115

And so back to the study in Europe…

- Prospective study over 12 months
- Linking life view to incidence of depression

Psychological Medicine, Page 1 of 12. © Cambridge University Press 2013
doi:10.1017/S0033291712003066

ORIGINAL ARTICLE

Spiritual and religious beliefs as risk factors for the onset of major depression: an international cohort study

B. Leurent[1,2], I. Nazareth[2], J. Bellón-Saameño[3], M.-I. Geerlings[4], H. Maaroos[5], S. Saldivia[6], I. Švab[7], F. Torres-González[8], M. Xavier[9] and M. King[1]*

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Background. Several studies have reported weak associations between religious or spiritual belief and psychological health. However, most have been cross-sectional surveys in the USA, limiting inference about generalizability. An international longitudinal study of incidence of major depression gave us the opportunity to investigate this relationship further.

Results: Link between “understanding of life” at baseline and onset of depression over 12 months.

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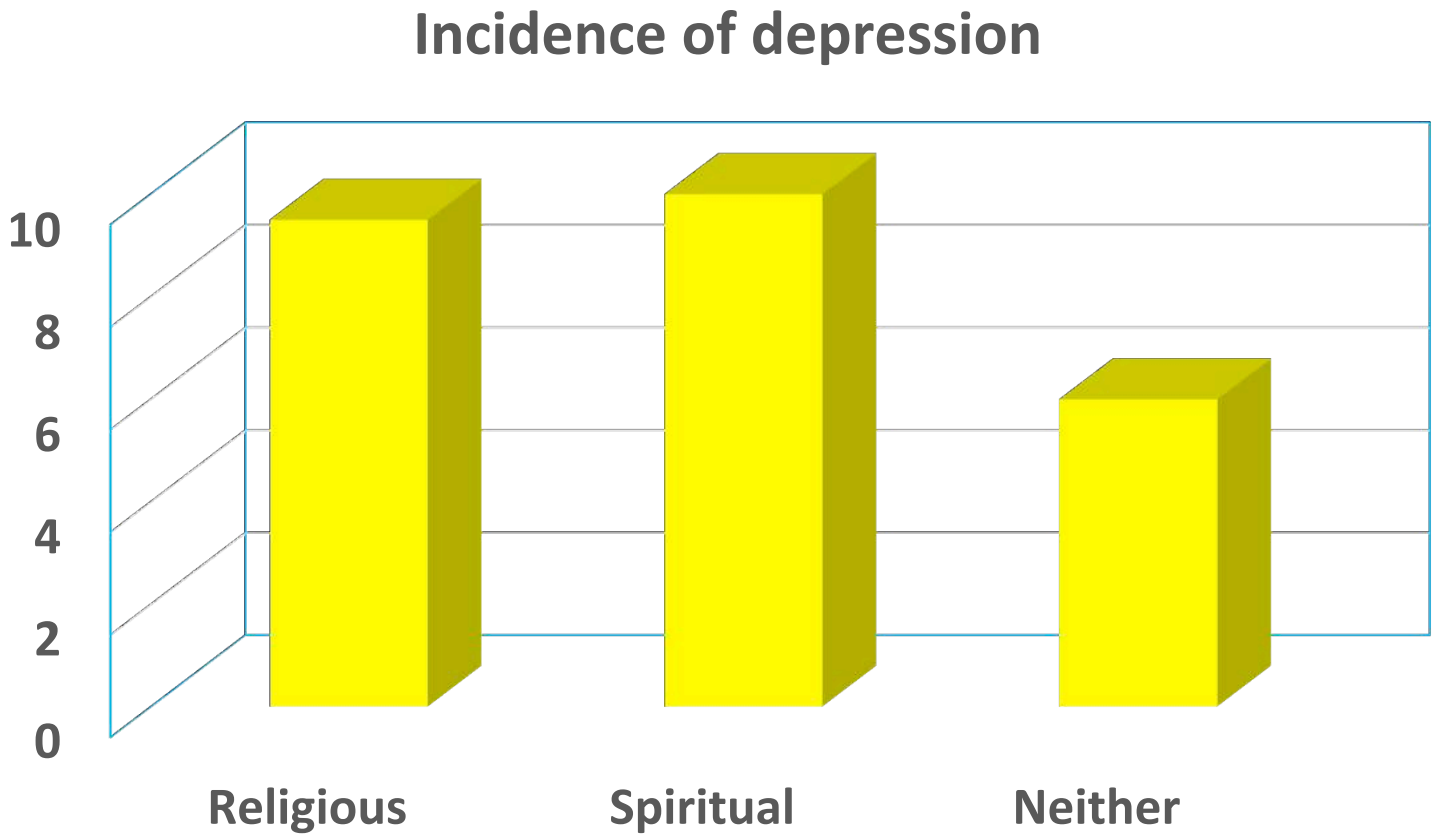

Adjusted odds ratio each group vs. ‘other’

- Religious 1.14
- Spiritual 1.32*

Did *strength* of belief in religious and spiritual people at baseline matter?

- Strength of belief is scored on visual analogue scale 1-6
- Higher = more strongly held

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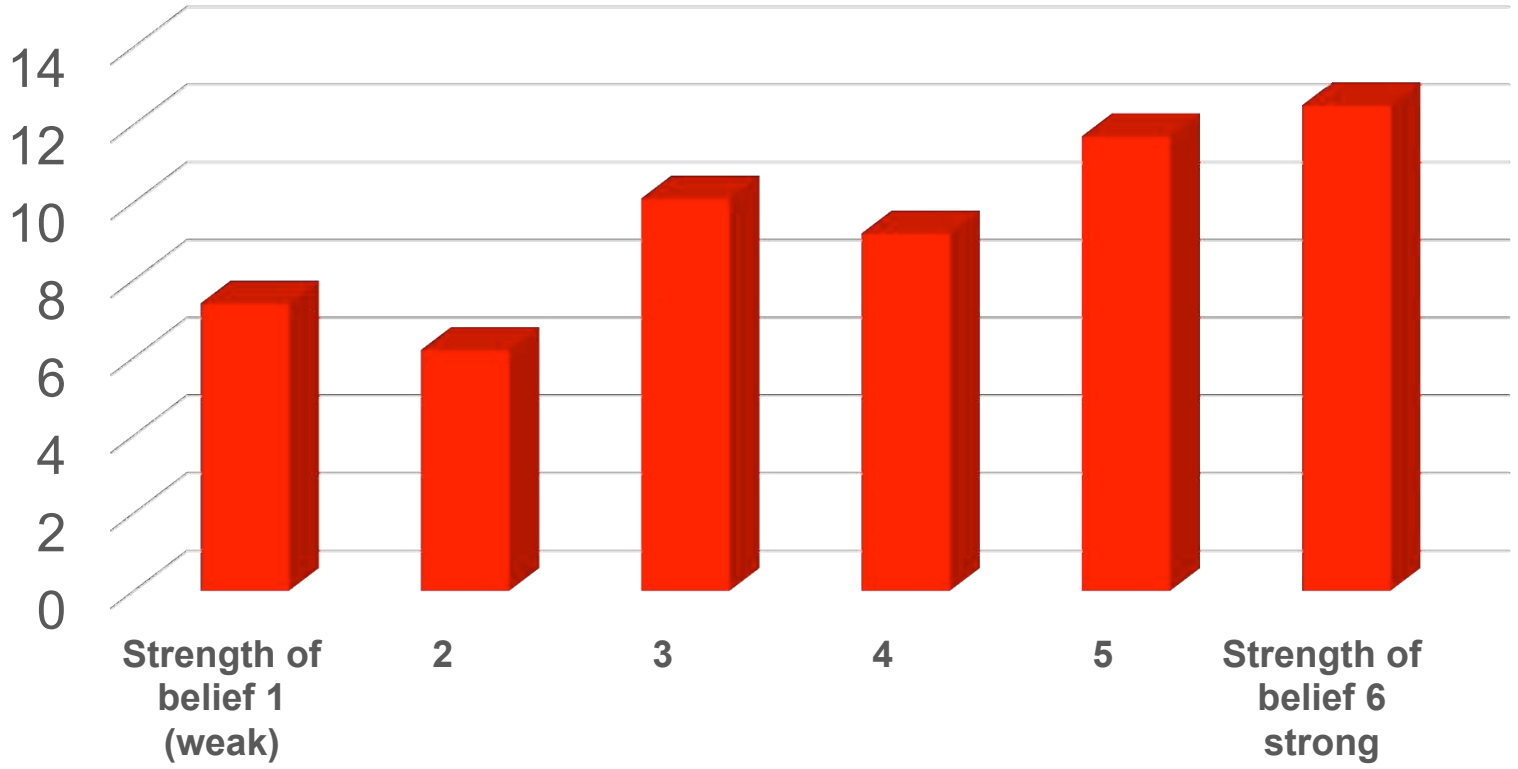
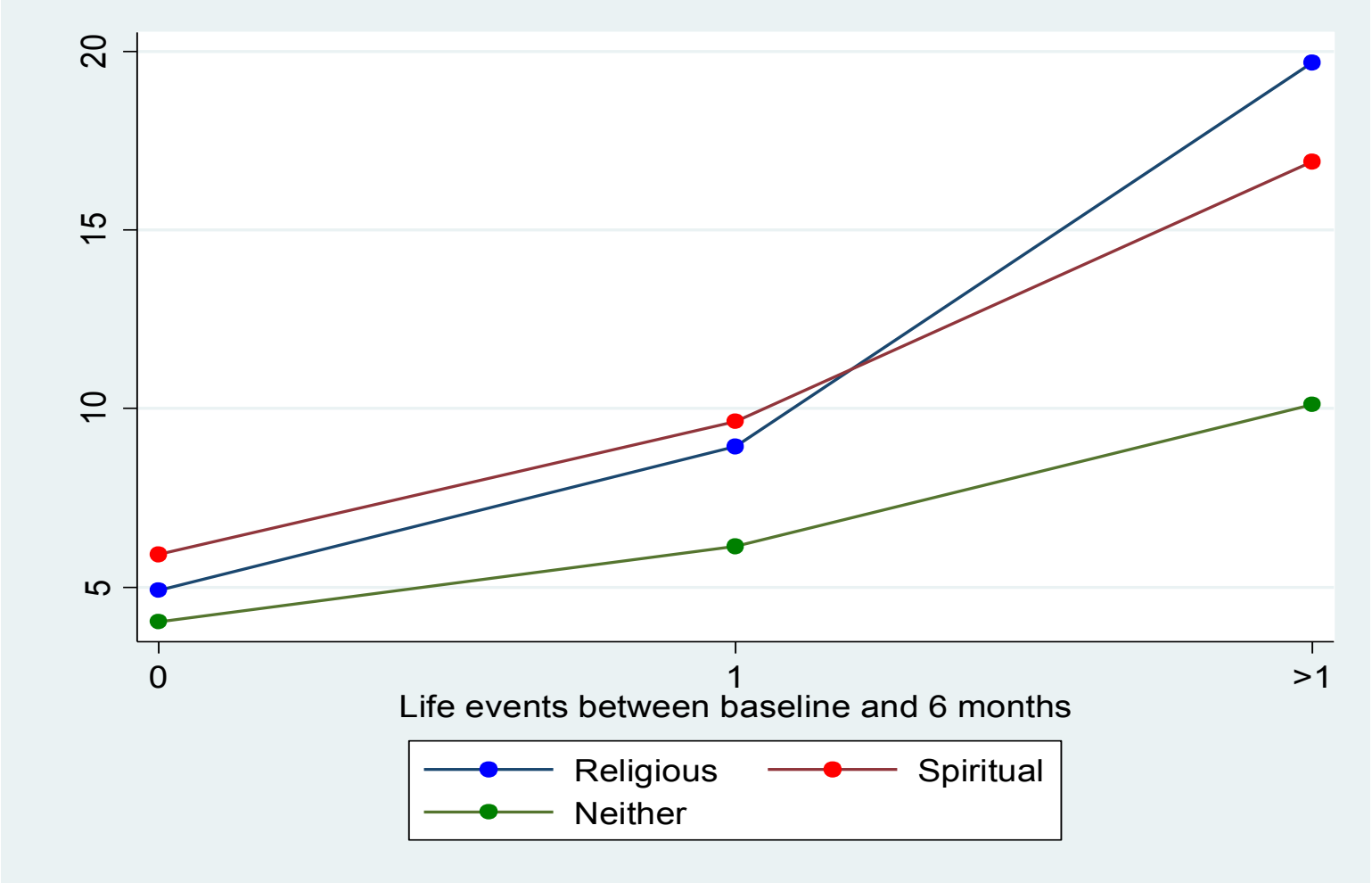


Did belief make a difference in times of stress?

- Could a religious and/or spiritual life view have a protective effect after major life events?
- A form of religious coping

Did belief make a difference in times of stressful life events?



Impact of life view on *recovery* of major depression

- Different population for analysis
  - Depressed at baseline (n=1,358)
- Proportion recovered by 6 or 12 months

Impact of life view on *recovery* of major depression

- Different population for analysis
  - Depressed at baseline (n=1,358)
- Proportion recovered by 6 or 12 months
- No effect

Conclusions

- Neither a religious nor spiritual life view *reduces* incidence of major depression
  - People with spiritual life view *may* have an elevated risk

- Although not all results in our prospective study reached statistical significance it is striking that there is no advantage in Europe for those with a religious life view

The story so far…

- Our results seem to go against the majority of North American research.

- Or does it?
  - What exactly is the evidence....?

Systematic reviews of the evidence

- Sanua, V. D. Religion, mental health, and personality: A review of empirical studies. *American Journal of Psychiatry*, 1969; 125(9), 1203–1213.

- Bergin, A. E. Religiosity and mental health: A critical re-evaluation and meta-analysis. *Professional Psychology: Research and Practice* 1983;14:170–84.

- Donahue, M. J. Intrinsic and extrinsic religiousness: Review and meta-analysis. *Journal of Personality and Social Psychology* 1985*;* 48:400–19.

- Bergin A E. Values and religious issues in psychotherapy and mental health. *American Psychologist 1991;* 46:394–403.

- Payne, I. R. et al. Review of religion and mental health: Prevention and the enhancement of psychosocial functioning. *Prevention in Human Services* 1991:9:11–40

Systematic reviews of the evidence cont'd

- Larson, D. B., et al. Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978–1989. *American Journal of Psychiatry*, 1992; 149;557–559.

- Smith et al. Religiousness and Depression. *Psychological Bulletin* 2003;129:614-636

- Hackney et al. Religiosity and Mental Health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion* 2003; 42:43–55

- Bonelli R & Koenig H G Mental Disorders, Religion and Spirituality 1990 to 2010: A Systematic Evidence-Based Review. *Journal of Religion and Health*. 2013 DOI 10.1007/s10943-013-9691-4.

- Chida Y, et al. Religiosity/spirituality and mortality. *Psychotherapy and Psychosomatics*. 2009; 78:81-90

Some reviews summarise findings by an unsophisticated adding up of positive studies regardless of size of effect or the play of chance

Studies	Findings
Larson, D. B., et al. (1992). Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978–1989. American Journal of Psychiatry, 149(4), 557–559.	72 % of studies reported a positive relationship between religious involvement and better mental health, 16% worse mental health, and 12% no correlation
Bonelli R, Koenig H G Mental Disorders, Religion and Spirituality 1990 to 2010: A Systematic Evidence-Based Review Journal of Religion and Health. 2013.	72% of studies reported at least one positive association and no negative associations

Systematic reviews – measures of association

Study	Findings
Bergin et al, 1983. Religiosity and mental health: A critical re-evaluation and meta-analysis.	Overall mean correlation of +0.09 between religiosity and “better mental health
Payne et al, 1991. Review of religion and mental health: Prevention and the enhancement of psychosocial functioning	No overall evidence for a relationship between religiosity and prevention of major clinical mental disorders
Smith et al. 2003. Religiousness and Depression	Correlation between “religiousness” and depressive symptoms -0.096
Hackney & Saunders, 2003 Religiosity and Mental Health: A meta-analysis of recent studies.	Overall correlation between religiosity and mental health 0.10
Chida et al. 2003. Religiosity/spirituality and mortality 2009	No impact on cardiovascular mortality in ill populations - but reduced mortality in well people HR 0.89. Mainly due to organisational religion (especially religious attendance)

And now more recent reviews in more specific areas of mental health..

- Cancer patients – 3
- Dementia patients - 1
- Adolescents -1

Sherman et al A meta-analytic review of religious or spiritual involvement and social health among cancer patients. *Cancer* 2015

- Primary objective
  - to examine the strength of relationships between social engagement/meaning and R/S involvement

- 78 independent samples encompassing 14,277 patients
  - All studies up to 2013
  - Most commonly studied social health variable was social distress social well-being

- Social health was significantly associated with overall R/S (Fisher *z* effect size = .20; *P* < .001)

Sherman et al A meta-analytic review of religious or spiritual involvement and social health among cancer patients. *Cancer* 2015

- Main associations with benign images of God and stronger R/S beliefs

- No significant effects for other R/S variables, such as
  - positive religious coping, private religious activities, or God locus of control (eg, health is controlled mainly by God rather than by clinicians or luck).

- The authors:
  - "The great majority of studies included in this meta-analysis were cross-sectional; thus, it is difficult to draw temporal or causal conclusions"…. "Moreover, the quality of studies reviewed was highly variable."

- The meta-analysis evaluated bivariate relationships;
  - associations between R/S dimensions and social health were not adjusted for covariates

Park et al – Religion/spirituality and health in the context of cancer. In *Cancer* Nov 2015

- Systematic review – three meta-analyses
  - 1341 effects, 44,000 patients

- Aim to identify the degree of association between measures of R/S and patient-reported health outcomes

Park et al

- Effect size for impact of R/S on mental health
  - 0.19 (148 studies, 617 effect sizes)
  - BUT some affective R/S dimensions (e.g. spiritual well-being and spiritual distress) *overlapped conceptually with many mental health endpoints* (e.g. emotional well-being and distress)

- Thus, after the exclusion of spiritual well-being
  - effect size fell to 0.09 (108 studies and 433 effect sizes).

Schreiber & Brockopp. What do we know about religion/spirituality and psychological well-being among breast cancer survivors? A systematic review. J Cancer Surviv (2012)

- Eighteen quantitative studies (January 1985 – July 2011)
- 1 RCT; 4 prospective, 13 cross-sectional

Schreiber & Brockopp. What do we know about religion/spirituality and psychological well-being among breast cancer survivors? A systematic review. J Cancer Surviv (2012)

- The RCT compared
  - A group intervention on use of meditation, guided imagery, nutrition, yoga and dance, with
  - Usual support group
- Poorly analysed – no differences between trial arms except for “spiritual integration”.

Schreiber & Brockopp – other findings

- No consensus on terms
  - spirituality, religion, and psychological well-being
- Phase of disease and/ or prognosis could each influence both well being and belief systems
- Multiple outcomes, small effects in longitudinal studies
- Results:
  - limited relationships between religion, spirituality, and psychological well-being.
  - various definitions used for the three variables
  - strength and clarity of relationships are not clear

Schreiber & Brockopp

- Nevertheless, the authors conclude:

- “There does, however, appear to be sufficient evidence to include a brief, clinically focused assessment of women diagnosed with breast cancer regarding the importance of a given belief system as they face the diagnosis and treatment of their disease”.

Agli et al. Spirituality and religion in older adults with dementia: a systematic review. *International Psychogeriatrics* 2014

- to examine the impact of spirituality and religion in dementia on
  - quality of life, their coping strategies, and cognitive function

- 11 studies (2003-2013)
  - 4 longitudinal, quantitative (usually weeks-months)
  - 6 moderate to high; 5 low quality

  - 1 was study of long term links between religious education and subsequent dementia (1628 men)
  - Other 10 – sample sizes 6-113 (some qualitative)

Agli et al. Spirituality and religion in older adults with dementia: a systematic review. *International Psychogeriatrics* 2014

- "In the majority of articles (10 on 11), positive effects of spirituality and religion were observed"

- But…
  - No effect sizes given and most of the results appeared to show minimal difference
  - 'Lack of rigor observed in the diagnosis of dementia'
  - Scales and questionnaires used to evaluate spirituality and religion were very different (from 2 to 15 items) and not always validated
  - No two studies used same instrument
  - "We can highlight a lack of methodological rigor in general"

Agli et al. Spirituality and religion in older adults with dementia: a systematic review. *International Psychogeriatrics* 2014

- And then – their conclusion in abstract:

- “Spirituality and religion appear to slow cognitive decline, and help people use coping strategies to deal their disease and have a better quality of life”

Yonker et al The relationship between spirituality and religiosity on psychological outcomes in adolescents and emerging adults: A meta-analytic review. J Adolescence 2012

- Publications 1990-2010:
  - 75 independent studies, 66,273 adolescents and ‘emerging adults’
- Mainly cross-sectional studies
  - often with convenience samples (most in USA).
- Small effect sizes risk behaviours (0.13-0.18)
  - Alcohol, drugs, smoking, sex
- Even smaller for depression and well being (0.11)
- No effect for anxiety

Yonker et al The relationship between spirituality and religiosity on psychological outcomes in adolescents and emerging adults: A meta-analytic review. J Adolescence 2012

- Effects mainly related to conventional measures of church attendance and salience (importance of religion)

- Spirituality in the more disconnected sense had little effect

What do we know about the effectiveness of ‘spiritual’ interventions/therapies?

What do we know about the effectiveness of 'spiritual' interventions/therapies?

- For example can we take greater account of beliefs and practice in psychotherapy?

- Mixed, fairly weak evidence that this might help but only in the more religious.

- Razali et al 2002 often quoted in support in reviews

Razali et al 2002

- 165 patients with GAD all received BZDs, supportive psychotherapy and relaxation
- “study group” also received a therapy that incorporated guidance from the Koran
- Not clear whether only religious participants were randomised

Razali et al 2002

- Reported a transient advantage (2 points on Hamilton) at 4 and 12 but not at 26 weeks.

- Quality of the trial low. Nevertheless..
  - This trial was quoted approvingly in a review of "Religion, spirituality and mental health in the West and the Middle East"

ORIGINAL ARTICLE

Religious *vs.* Conventional Cognitive Behavioral Therapy for Major Depression in Persons With Chronic Medical Illness

A Pilot Randomized Trial

Harold G. Koenig, MD,†‡§‖ Michelle J. Pearce, PhD,*§¶ Bruce Nelson, MA,# Sally F. Shaw, PhD,# Clive J. Robins, PhD,** Noha S. Daher, DrPH,†††‡ Harvey Jay Cohen, MD,†§ Lee S. Berk, DrPH,§‡‡‖‖‖ Denise L. Bellinger, PhD,‖‖‖ Kenneth I. Pargament, PhD,¶¶ David H. Rosmarin, PhD,## Sasan Vasegh, MD,*** Jean Kristeller, PhD,††† Nalini Juthani, MD,‡‡‡ Douglas Nies, PhD,# and Michael B. King, MD, PhD§§§*

Abstract: We examine the efficacy of conventional cognitive behavioral therapy (CCBT) versus religiously integrated CBT (RCBT) in persons with major depression and chronic medical illness. Participants were randomized to either CCBT (n = 67) or RCBT (n = 65). The intervention in both groups consisted of ten 50-minute sessions delivered remotely during 12 weeks (94% by telephone). Adherence to treatment was similar, except in more religious participants

depression and faster recovery from depression (Koenig, 2007; Koenig et al., 1992, 1998). Psychotherapy that integrates the religious beliefs of medically ill clients into therapy may be particularly effective in relieving depression in this setting.

Cognitive behavioral therapy (CBT) is a standard treatment of depression (Butler et al., 2006). Not surprisingly, psychological approaches such as CBT have been particularly effective in treating depression in

Can incorporation of religious and spiritual beliefs enhance a talking therapy?

- Hypothesis:
  - RCBT is more effective than CCBT in participants with depression who are at least somewhat religious or spiritual

- RCT – 65, 67 in each arm
  - Conventional cognitive behavioural therapy versus
  - Religiously integrated CBT

Can incorporation of religious and spiritual beliefs enhance a talking therapy?

- No significant difference (BDI) between the two therapies in outcome after 12 weeks
- Response rates and remission rates were also similar.

Can incorporation of religious and spiritual beliefs enhance a talking therapy?

- No significant difference (BDI) between the two therapies in outcome after 12 weeks
- Response rates and remission rates were also similar.
- So what is the review evidence on this but in different realms?

Candy et al – Spiritual and religious interventions for well-being of adults in the terminal phase of disease. Cochrane Review 2012

- RCTs that involved adults in the terminal phase of a disease
- If the trial evaluated outcomes for an intervention that had a spiritual or religious component

Candy et al – Spiritual and religious interventions for well-being of adults in the terminal phase of disease. Cochrane Review 2012

- Five RCTs (1130 participants) were included
  - X2 Meditation with a spiritual component
  - X3 Team approaches with spiritual members

- Primary outcomes were well-being, coping with the disease and quality of life

Candy et al – Spiritual and religious interventions for well-being of adults in the terminal phase of disease. Cochrane Review 2012

- Five RCTs (1130 participants) were included
  - X2 Meditation with a spiritual component
  - X3 Team approaches with spiritual members
- Primary outcomes were well-being, coping with the disease and quality of life
- No significant effects

Fitchett et al Care of the human spirit and the role of dignity therapy: a systematic review of dignity therapy research

- Therapy for people with serious illness
  - dignity conservation tasks such as settling relationships, sharing words of love, and preparing a legacy document for loved ones
- Has spiritual components

Fitchett et al Care of the human spirit and the role of dignity therapy: a systematic review of dignity therapy research

- High satisfaction but
- No discernible impact on physical or emotional symptoms

What about interventions which contain components of ‘secular spirituality’

Meditation in the absence of religious or spiritual belief

- Goyal et al. Meditation Programs for Psychological Stress and Well-being: Systematic Review and Meta-analysis. *JAMA Int Med* 2014

- 47 trials with 3515 participants.

Meditation in the absence of religious or spiritual belief – effect sizes

- Mindfulness meditation programs had moderate evidence of improved:
  - anxiety (0.38 [95% CI, 0.12-0.64] at 8 weeks 0.22 [0.02-0.43] at 3-6 months),
  - depression (0.30 [0.00-0.59] at 8 weeks and 0.23 [0.05-0.42] at 3-6 months),
  - pain (0.33 [0.03- 0.62])

- Low evidence of improved stress/distress and mental health–related QoL

- No effect or insufficient evidence of any effect of meditation programs on positive mood, attention, substance use, eating habits, sleep, and weight

- No evidence that meditation programs were better than any active treatment (i.e, drugs, exercise, and other behavioral therapies).

What to make of all this?

- Different claims for the strength of evidence
- Although there is some consistency in the direction of the evidence, the advantage is not particularly important in the clinical sense
- Strongest evidence in mental health and substance misuse is for religious belief, religious life view, religious practice
  - But even here effect sizes are often small
- Most secure evidence concerns suicide

Mechanisms in religion and health

- Regulation of lifestyles and health behaviours.
  - Less ‘risky’ behaviour
- Provision of social resources/support
- Sense of belonging (to the saved?)
- Promotion of positive self-perceptions
- Provision of specific coping resources.
- Generation of other positive emotions.

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- Strongest evidence in mental health and substance misuse is for religious belief, religious life view, religious practice
  - But even here effect sizes are often small
- Most secure evidence concerns suicide
- Spirituality in the absence of religious practice seems to be less certain and less positive

There is also the quality of the evidence to consider

Common research issues

- Difficulties & inconsistencies of measurement
- Searching for any kind of association
  - No clear primary outcome linked to a hypothesis
  - No clear *a priori* analysis plans
  - Many small effects, multiple testing, no consideration of interactions
- Reverse causality
  - are the healthy more concerned about spirituality?
  - are church attendance and better mental health determined by other personality and cultural factors?
- Residual confounding – other influences we don't know to take into account
- Conscious and unconscious bias of the researchers and reviewers

And possibly key – the comparison group

- Spirituality needs to be compared with other (secular) strong claims on meaning/belief
- Comparison groups are often ‘everyone else’ grouped into a whole
- But ‘everyone else’ is a complicated mix of people most of whom have beliefs of some sort….
- E.g. what about atheists?

When believers and atheists are compared

- Weber, Pargament et al 2011. Psychological Distress Among Religious Nonbelievers: A Systematic Review
  - 14 articles that examine differences between nonbelievers and believers in levels of psychological distress, and potential sources of distress among nonbelievers.

When believers and atheists are compared

- Nonbelievers are more likely than believers to struggle with anger toward God and difficulty forgiving God (2 studies from the same group).
  - Hardly surprising but one wonders about the context.

- Atheists *are just as well or better off* than their believing counterparts in terms of
  - coping with the challenges of old age
  - overall happiness

So – what to make of all this?

Final thoughts:

If religion makes people happy, why are so many dropping out?

Lewis and Lanigan 1997
Diener et al. 2011

Final thoughts

- Religion, spirituality and a search for meaning are important in some form to all people
- So of course we should consider them in clinical work in mental health
- However, we should be more circumspect in our claim that this leads to greater well being and less mental disorder
- Spirituality cannot be brought under human control, cannot be used in order to increase well-being or to augment mental health