The Argument for the Inclusion of Spirituality

Charles L. Zeiders, Psy.D.
James L. Schaller, M.D., M.A.R.

Framing the arguments for and against spirituality and religion in mental health theory and practice, this article supplies manifold examples of reviewed scientific evidence to support the notions that spirituality can be empirically distinguished as an expressly positive force in mental health. Such findings support the yearnings of many patients and practitioners to include the spiritual in mental health theory and practice. It is suggested, however, that exuberance for the spiritual—however based in research—should balance itself with an understanding of the existing impediments to the inclusion of spirituality in mainstream clinical and academic psychology and psychiatry, suggesting that even more research will be required before the establishment of widespread acceptance.

Are spiritual people psychologically immature? Does religion help the mind? Arguments for and against spirituality and religion are not new within the mental health disciplines. Until lately, the argument against or indifference to spirituality has been the ascendant one. An accumulation of recent research, however, suggests that religious and spiritually oriented people are benefiting from their faith. Such data supports patients and practitioners of psychology and psychiatry who seek to include the spiritual in their theoretical paradigms and practical intervention. Important impediments exist, however, that prevent spirituality and religion from finding greater acceptance in the fields of mental health—suggesting that still more research will have to be conducted before this aspect of human experience is incorporated into the mental health equations by which psychologists and psychiatrists operate.

Spirituality: Unscientific, Infantile, Pathological

One school of thought advocates that spirituality is unscientific, infantile, and pathological. Freud held all three views. His biographer Gay (1988) interprets

> If religion—from the most primitive sacrifice to the most elaborate theology—is infantile fear, awe, and passivity carried over into adult life, then science, as a psychoanalyst might put it, is an organized effort to get beyond childishness. The scientist disdains the pathetic effort of the believer to realize fantasies through pious wanting and ritual performances ... (p. 534)

Agreeing with Freud, emphasizing the pathological, some psychiatrists have labeled spirituality "Borderline psychosis ... A regression, an escape, a projection upon the world of a primitive infantile state" (Group for the Advancement of Psychiatry, 1976). Some reduce spirituality simply to a "psychotic episode" (Horton, 1974) or localize it to a reductionistic "temporal lobe dysfunction" (Mandel, 1980). Ellis associated the religious with the irrational and expected it to lead to poor mental health (Worthington, Kurusu, McCullough, and Sandage, 1996). The National Academy of Sciences (1996) supported Freud's ideology that religion was not compatible with science by their contention that spirituality and science were "mutually exclusive realms of thought."

Spirituality: Verifiable, Mature, and Healthy

Another school of thought seeks to marry spirituality and science, facilitate human maturation through spirituality, and harness health from it. Deikman (1980) argued that spirituality represents "a non-ordinary door to satisfaction." He lamented that

> our cultural bias … tells us that [spiritual] states are unreal, pathological, 'crazy' or 'regressive;' it is a bias that declares the entire area to be 'subjective' and, therefore, 'unscientific.' We have been indoctrinated neither to make use of nor to look closely at these realms ... under the banner of the scientific method our thinking has been constricted. It is time we made the [spiritual] ... a legitimate option for ourselves and for science (p. 268).

Psychologists William James (1902) and Evelyn Underhill (1910) studied spiritual experience of ordinary people and great mystics. Encounters with the divine, they concluded, have the capacity to console, heal, and pull individuals to higher levels of health and maturity. More recently Peck (1978) observed that a supernatural health force or "grace," may operate not only to beat pathology but to nurture and spur individuals into a developmental epoch of "Spiritual Competence."

A new and growing body of empirical evidence supports this latter school of thought. Spirituality can be scientifically studied, and it can be established that spiritual people benefit from their spirituality measurably and in the direction of psychological and physical health.

Religious Commitment and Well-being

Studies show that spirituality has beneficial effects upon important measures of well-being. A cross-sectional survey designed by Ellison and George (1994) concluded that church attendance improves the quantity and quality of social support. Heart surgery patients who identify themselves as "deeply religious" tend to have lower postoperative mortality rates (Oxman, 1995). A survey of adults (Hadaway & Roof, 1978) found that the importance of religion directly related to feeling worthwhile and that worthwhileness was also tied to church attendance. A study of childhood risk factors associated religious involvement with fewer behavior problems and higher maturity measures for children and adolescents (Cohen & Brook, 1987). A survey of college students found that students affiliated with Christian religious groups scored better on indices of well-being than non-affiliated students (Frankel & Hewitt, 1994). McNamara and George (1979) conducted a national survey that found religiosity to be significantly and positively correlated with quality of life measures, including mood, marital satisfaction, family life, and general satisfaction. Glenn & Weaver (1978) also found church attendance to strongly and positively correlate with marital happiness. Patients with hip fractures and high religious commitment experience greater well-being than non-religious patients, as measured by lower depression scores and an ability to walk farther distances at discharge (Pressman, Lyons, Larson, & Strain, 1990). Religiously involved adolescents have lower rates of delinquency, alcohol, and drug use than less spiritual peers (Burkett & White, 1974). In a national survey sample, using a religiously oriented survey instrument, Watson, Hood, Morris and Hall (1985) found that viewing religion as the central end around which life is organized positively relates to self-esteem. Overall, findings seem to suggest that going to church and keeping spirituality as a central life focus predicts, and/or correlates with doing well on various measures of well-being.

Spirituality and Psychopathology

In addition to positively correlating with indices of well-being, spirituality may negatively correlate with psychopathology. Church attendance is inversely related to the development of diagnosable mental disorders (Koenig, George, Meador, Blazer, and Dyck, 1994) and religious practices such as prayer, scriptural study and church attendance decreases the risk of developing alcoholism (Koenig, George, Meador, and Ford, 1994). Religious people tend to have better moods than non-religious people (McNamara & George, 1979). Older persons with intrinsic religiosity are less likely to have anxiety about death than younger persons with less religiosity (Thorson & Powell, 1990). Young people also fear death less if they are religious (Richardson, Berman, Piwowarski, 1983). Religiosity was negatively correlated with deviant attitudes and deviant behavior in a sample of high school and college students (Rohrbaugh & Jessor, 1975). Emotional health of caregivers to chronically ill people positively correlates to religious faith (Rabins, Fitting, Eastham, and Fetting, 1990). Hospitalized elderly men who cope using religion have lower depression scores than less religious peers (Koenig, Cohen, Blazer, Pieper, Meador, Shelp, Goli, and DiPasquale, 1992). Public religiosity is associated with lower depression risks for disabled men (Idler & Kasl, 1992). Religiousness is negatively associated with drug use among teenagers (Hays, Stacy, Widaman, DiMatteo, and Downey, 1986). Religious adults are less likely to have psychiatric symptoms than nonreligious adults (Hannay, 1980). People who attend religious services at least once a month report fewer psychological symptoms than those with no religious affiliation (Hannay, 1980). Religious belief correlates inversely with schizotypal thinking in normal subjects (Feldman & Rust, 1989). A survey of one hundred thirty two 15-year-old girls found that positive attitudes toward religion negatively correlate with psychotic personality traits (Francis & Pearson, 1985). Opioid addicts who participated in a religious treatment program remained abstinent at a one year follow-up, compared to 5% of addicts who underwent a non-religious treatment program (Desmond & Maddux, 1981). Harvard divinity students who have undergone a deep spiritual experience score lower on indices of hostility and higher on measures of self-confidence in the face of stress than peers who have not experienced their "ground of being" (Kass, 1996, SP1). Nine

empirical studies have been conducted since 1951 that negatively correlate four dimensions of spiritual wellness (meaning in life, intrinsic values, transcendence, or membership to spiritual community) to depression, showing empirical "support for a relationship between depression and each of the four dimensions of spiritual wellness" (Westgate, 1996, 32).

Prayer and Psychologically Relevant Findings

Just as spirituality and religion can predict low psychological symptomatology, several empirical studies suggest that prayer correlates with psychologically positive findings. Questionnaire research conducted with 100 AA members in southern California found that prayer was positively correlated with life purpose and length of sobriety (Carroll, 1993). Of over 300 randomly selected people suffering from musculoskeletal pain, 44% of respondents reported praying to cope with pain, 54% of that group further reporting, that prayer was "very helpful" (Cronan, Kaplan, Posner, Blumberg, & Kozin, 1989). In a survey of 100 Catholic widows, researchers found 89% declared prayer useful for coping with husband loss (Gass, 1987). Prayer research has also shown frequency of prayer to positively associate with marital adjustment (Gruner, 1985). Use of prayer negatively relates to death anxiety in older adults (Koenig, 1988). For sixth and seventh graders in a longitudinal study, prayer with parents negatively related to alcohol use (Long & Boik, 1993). For 560 randomly sampled adults in Akron, Ohio, frequent prayer positively related to existential well-being (Poloma & Pendleton, 1991). Frequent prayer and spiritual experience during prayer, like feeling energy or feeling God's presence, positively relate to purpose in life (Richards, 1990, 1991). In a survey of 100 coronary surgery patients, 95 reported using prayer as a coping behavior, with 70 rating prayer "very helpful" to help them deal with the ordeal (Saudia, Kinney, Brown, and Young-Ward, 1991). A survey of 25 cancer patients found that, of the spiritual strategies available, prayer was the strategy patients used most frequently to cope (Sondestrom & Martinson, 1987). In a survey of Illinois physicians who pray with older patients, researchers found that 89.3 percent of the physicians felt that praying with older patients helped patients somewhat or a great deal (Koenig, Lucille, Dayringer, 1989). In a double blind experiment comparing prayed-for and not prayed-for coronary patients, Byrd (1988) found that prayed-for patients required fewer antibiotics, had less pulmonary edema, and needed fewer intubations. A survey of cystic fibrosis patients and their families showed that the most common non-medical treatment used by respondents was group prayer, with 93% of frequent group prayer users perceiving benefit from this prayers (Stern, Cana, Doershunk, 1992). A group of college students practicing standardized prayer experienced decrease in muscle tension and scored lower on indices of anger and anxiety than counterparts practicing secular progressive relaxation (Carlson, Bacasta, and Simanton, 1988). Survey data indicate that a strong connection exists between frequent prayer and positive behavior towards others, and in interview situations people who prayed frequently were judged by raters to be more cooperative and friendly (Morgan, 1983). A review of 150 studies of prayer and prayer-like techniques used to produce positive effects on enzymes, plants, animals, and people, found that over half of these scientific studies yielded significant, positive results, leading one reviewer to note that if "healing were a medication it would be on the market" (Benor, 1992, 74).

The Need for Psychiatry and Psychology to Not Exclude the Religious

From the above, one notes that medical and social science has produced a plethora of information contradicting anti-spiritual bias in psychiatry and psychology. Some reviewers have found religion to have a positive impact on clinical results 84 percent of the time. These findings present a strong argument for the inclusion of spirituality in psychiatric and psychological treatment plans. This positive inclusion of spiritual considerations and interventions are demanded by demographic realities: 95% of the American population believes in God, 50% pray daily, and 40% attend religious services (Gallup, Report #236, 1985; Bergin & Jensen, 1990). But not only are many American people spiritual, they want their caregivers to respect their spirituality and address their care needs on that level: 77% of patients feel that physicians should consider their spiritual needs, 48 % of patients want their physician to pray with them, and 37 % of patients want their physician to discuss religious beliefs with them (King & Bushwick 1994). Further survey data suggests that caregivers such as psychologists would be willing to move in that direction: 75% of surveyed psychologists felt that religious issues were within the scope of the clinical setting, and 90% felt that asking about and understanding their clients' religious backgrounds was clinically important (Shaftanske & Malony, 1990). All this points to the current need in psychiatry and psychology for religious and spiritual literacy. Since empirical evidence exists to support the health efficacy of the spiritual, and since both clients and some care givers respect spirituality, and since both clients and some care givers want to share with one another in spiritual terms, there is—in short—a need to do so.

The Ongoing Struggle for Acceptance

Despite promising research and grass-roots support for inclusion of spirituality in mental health, acceptance is likely to be a difficult. Three factors account for this. First, psychology and psychiatry have absorbed and de-mystified the mental healing mission originally conducted by the church, and those disciplines may not wish to incorporate spirituality from a vanquished way of healing. Second, the current mental health paradigm is a-religious. By nature, paradigms remain impervious to extra-paradigmatic information; so the existing structure may remain impervious or at least highly resistant to extra-paradigmatic spirituality, despite compelling new evidence. Third, a practitioner's own psychological issues and counter-resistance to the demanding aspects of the religious experience, may prevent mental health theoreticians (and policy brokers) from making the divine admissible in the treatment arena. These hurdles warrant further elaboration.

Before the existence of psychology and psychiatry in Western civilization, the Christian church ministered to psychological needs. In the fourth century, for example, John Chrysostom developed treatments for grief, and in the early 16th century, Martin Luther developed instructions for consoling an anxious man (Clebsh and Jackie, 1983). With the rise of theistic science and the tide of antireligious sentiment that eventually came from its children, the mental health mission of the church lost ground to reductonistic psychology and psychiatry. Despite the inclusion of the new "V" code for spiritual and religious problems in the *DSM-IV* (APA, 1994) and the apparent explosion of new religious treatment research, the mental health establishment may remain loath to incorporate spirituality from traditions that appear to have lost their ministry and authority in this area to scientific psychology and psychiatry.

The next hurdle that impedes the inclusion of spirituality into mental health involves the nature of paradigms. In *The Structure of Scientific Revolutions* (1962), Kuhn argues that scientists bring to the table ultimate metaphysical presuppositions, often unconscious, which cause them to dismiss legitimate scientific evidence. Kuhn teaches that the only way an ultimate presuppositional scientific paradigm can be challenged is when vast amounts of data cannot be made to fit into the paradigm. Since theorists are ingenious at explaining away data that contradicts their ultimate presuppositions (e.g. a "square" is really two of my triangles fitting neatly into my triangle paradigm) a vast amount of conclusive research will have to be accomplished before the existing paradigm accepts the revolutionary finding that spirituality benefits mental health.

Finally, psychological and existential factors may influence brokers of mental health theory and practice in such a manner that they disavow the spiritual in their professional work for personal reasons. For example, Vitz (1990) demonstrates that famous thinkers of the past have had one or both of their parents leave them through death, abandonment, or abuse. Votaire, Feuerbach, Neitzsche, and Bertrand Russell are examples of men whose "orphan psychology" (Schaller, 1995) influenced their agnostic or atheistic stance. Someone who experiences a poor relationship with a parent can generalize this experience to an unconsciously motivated yet profound rejection of God; therefore, they reject God, not based on scientific data, but due to their unconscious, unmetabolized woundedness. These dynamics can influence the attitudes of mental health theorists and practitioners against spirituality,

Moreover, religion throughout history has posed an existential threat to humans. If God exists, there may be certain obligations and elements of accountability which may intimidate the beholder of the divine. Indeed, in the Hindu religion, God as Kali is depicted with fangs and skulls hanging around her neck. In Judaic and Christian scripture, God is not merely loving and forgiving but also a holy and fearsome judge. We should appreciate the dynamics of psychologists and psychiatrists who avoid embracing religion and spirituality, because of possible core psychological fears, wounds and object-relations problems, where God is not merely caring but also One to Whom one is accountable. Existential intimidation can lead psychologists and psychiatrists to deny spiritual realities.

Conclusion

Scientific evidence has been mounting to support the notion that religious and spiritual beliefs and practices represent beneficial factors for improving mental health. While existing new research contradicts the anti-spirituality argument, and lends credibility to the yearning of many patients and practitioners to include spirituality within the scope of mental health theory and practice, it will take years to develop a widespread acceptance of the importance of spirituality within psychology and psychiatry. Reasons for this include the assumption and de-mystification of the church's mental health ministry, the nature of scientific

paradigms, and finally human nature itself. An overabundance of more evidence will be needed to establish a positive place for spirituality within the realm of mental health.

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James Schaller, M.D., M.A.R. is a doctor, an adult psychiatrist, a fellow in child and adolescent psychiatry, frequent mental health radio show guest, and a theologian. He was associated with the Eastern Pennsylvania Psychiatric Institute and is now in private practice in Naples, FL, working both clinically and as a researcher, in addition to being a graduate level counseling and psychology teacher. He is author of The Search for Lost Fathering*, along with a number of other academic psychiatry articles. He is one of only a few theologically trained child and adult psychiatrists in the country.*

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