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Social Support and Religion: Mental Health Service Use and Treatment of Schizophrenia

A. Smolak[*], **R.E. Gearing**[*], **D. Alonzo**[*], **S. Baldwin**[*], **S. Harmon**[*], and **K. McHugh**[*]
[*]Columbia University School of Social Work, 1255 Amsterdam Avenue, New York, New York 10027

Introduction

For individuals with mental disorders and their families, religion and spirituality may exert significant influence over how these conditions are understood, treated, and managed. During times of stress or personal difficulty individuals frequently turn to religion and spirituality for support and solace (Schuster et al., 2001). Although historically understudied and minimized by mental health professionals (Borras et al., 2007), religions increasingly being examined for the role it plays in the treatment of patients with mental disorders, specifically schizophrenia spectrum disorders (Bhavsar & Bhugra, 2008; Koenig, McCullough, & Larson, 2001; Ng, 2007; Pargament, 1997; Verhagen, 2010). Research has increasingly found that religion and spirituality play an important role for individuals with a psychotic disorder (Ng, 2007), and it has been associated with measures of well-being among persons with schizophrenia (Corrigan et al., 2003). Religion and spirituality can have a positive influence on persons with schizophrenia, and on their treatment (Gearing et al., 2011; Koenig, 2009).

The role that religion and spirituality exerts on a patient's support networks, including families, mental health professionals, spiritual leaders, and the public, has received less scientific scrutiny. The multiple routes in which social support effects persons with schizophrenia and their networks have been reported to be a protective for coping and engaging in treatment (Buchanan, 1995; Gearing, 2008; Magliano et al., 2002; McCorkle, Rogers, Dunn, Lyass, & Wan, 2008; Rüesch, Graf, Meyer, Rössler, & Hell, 2004). Families often hold a bridging and gate-keeping position connecting patients to the larger community and to mental health professionals. Given that family units are likely to be important moderators and determinants of the framework in which patients with psychosis interpret and explain internalized events (Mohr et al., 2010), it is important to understand familial associations of religion with these conditions.

The religiosity of mental health professionals can similarly influence patients managing a serious mental illness. However, mental health professionals are often unaware of the religious beliefs of their patients (Borras et al., 2010). Not only can family beliefs influence patients with a psychotic condition, professionals' lack of religious belief or inherent religious bias may also exert an influence on patients (Ng, 2007). It has been posited that there is a growing 'religious gap' between a smaller proportion of U.S. psychiatrists who believe in God compared to the beliefs held by the general population (Ng, 2007; O'Connor & Vandenberg, 2005; Pierre, 2001). Mental health professionals' religious beliefs may result in the minimizing or pathologizing of a patient's religiosity. However, the separation of religious context from the professional treatment of mental health is growing narrower, as

Corresponding author: Alex Smolak, PhD(c), MSW as3234@columbia.edu.

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evidenced by an increase in publically funded studies, scholarly articles, and peer-review journals addressing the topic of religion and mental health. This narrowing may be partially driven by the presence of religion in current world events intersecting with the mental health profession's growing interest in the impact of environment on mental health, or by the frequency of religious or existential themes initiated by clients. The increase in recognition and research on the interface between religion and schizophrenia unveils the influence of religion on the support structure of people with schizophrenia and the implications of this influence on coping, help-seeking, and treatment engagement.

The interactions between religion and the support given by family members, mental health and health care professionals, and the larger public represent a gap in the field of mental health. This study investigates the religious and spiritual perceptions of families, professionals, and the public in order to illuminate an aspect of the environment in which persons with schizophrenia are contextualized. This study aims to explore the religious perceptions of professionals, family members, and the public regarding the etiology of schizophrenia, and its impact on help-seeking behavior and treatment for individuals diagnosed with schizophrenia. The influence of religious perceptions of patients with schizophrenia is also explored, but only as it relates to their treatment engagement and help-seeking behaviors.

Methods

PsycINFO and MEDLINE databases were searched for articles published over the past 30 years, from January 1, 1980 to January 1, 2010. The search was conducted by the authors with assistance of a librarian. References of articles were evaluated for additional studies. Authors of articles and colleagues were consulted with in order to find additional studies. The search included studies matching the following criteria: 1) investigated individuals with schizophrenia spectrum disorders, specifically including schizoaffective, schizophreniform, psychotic disorder, and psychotic disorder NOS; 2) investigated perceptions of professionals, family members or the public regarding schizophrenia; 3) investigated religion, religiosity, spirituality, or faith; 4) published in the English language; and 5) published as peer-reviewed articles. Exclusion criteria included: 1) studies that did not directly investigate patients with schizophrenia spectrum disorders; 2) studies that did not directly investigate perceptions of professionals, family members or the public regarding schizophrenia; 3) studies that did not specifically address schizophrenia and religion; 4) literature reviews; 5) single case studies; and 6) letters to the editor.

The articles included in this review were assessed by the research team according to established criteria, resulting in the inclusion of 43 original research studies. Data extraction forms were developed to identify patterns and themes by reviewing of the content of each study and noting all themes. Patterns emerged that allowed for grouping study findings into four categories: etiology, coping, engagement and help-seeking, and treatment. These categories were used to organize this systematic review. All other thematic categories had two or less studies. The studies in these other categories were primarily centered on one of the other four major categories. The eligible studies were independently reviewed by the authors and coded into the following categories: etiology, coping behavior, engagement and help seeking behavior, and treatment behavior. The authors maintained over 95% inter-rater reliability across all articles. Discrepancies in coding were resolved through discussion and consensus.

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Results

Forty-three studies were included in this review. One (2%) study was published in the 1980s, 10 (23%) studies were published in the 1990s, and 32 (74%) were published between 2000 and 2010. Twelve (28%) of the studies described studies conducted in the United States, and 18 (42%) were from other countries. The studies investigated the perspectives of family members, professionals, and/or the larger public. Eighteen (42%) articles studied family perceptions and attitudes, with family defined as someone who is a relative or caregiver of an individual diagnosed with schizophrenia. Ten (23%) studies investigated professional perspectives, which are defined as mental health professionals, medical professionals, religious leaders, clergy, or healers. Fourteen (33%) studies researched public attitudes, with public defined as anyone in a community who is not a relative of a patient with schizophrenia or a religious, medical, or mental health professional. Lastly, one (2%) studies studied a combined group of family, professionals, and the public. The studies averaged 154 participants per study with a standard deviation of 192. The median was 78 participants. The mean age overall was 41years (SD ±12). Exempting the seven (16%) studies that did not provide gender breakdown, 56% (SD ±19%) of the participants across all studies were male.

There was much diversity in the methodological approach employed by the studies. Sixteen (37%) studies solely used interviewing, which is defined by using standardized questions in a semi-structured question and answer session. Eighteen studies (42%) only used questionnaires, which is defined as paper-and-pencil measures. The remaining nine (21%) studies used multiple research methodologies. The studies can further be classified as utilizing vignettes or comparisons. Vignettes were endorsed when researchers discussed using vignettes of an individual with mental illness or religious affiliation as a part of their methodology. Twelve (28%) studies used vignettes. Sixteen of the 43 investigations (37%) compared the groups within the study sample when analyzing data.

Perceptions of Etiology

Twenty-six studies investigated the perceived etiology of schizophrenia from non-patient perspectives. These perspectives include professionals (broadly defined as healers, clergy, and mental health professionals), family members (relatives and primary caregivers), and the public. Most studies investigated causal attributions from a family perspective, 10 from a public perspective, three from the perspectives of both mental health professionals and healers, and two from the perspective of clergy. The religious affiliations of the participants in the studies were also presented, if participants of a specific religious affiliation accounted for greater than 5% of the total population in the study. Religious affiliation was investigated in 16 (62%) of the articles; specifically, 10 studies investigated Christianity, 5 Islam, 3 Buddhism, 3 Hinduism, 2 Judaism, and 3 other religions. The religious affiliations in the "other" category include scientology, Pentacostalism, Kardecismo, and the Afro-Brazilian religions of Candomble and Umbanda.

Causal attributions were divided into eight categories: 1) sorcery/witchcraft (including black magic, curses, evil eye, bewitchment), 12 studies; 2) punishment from God (including implications from God, divine wrath, God's will, making God angry, breaching the taboos of God), 9 studies; 3) possession (including spirit intrusion and exorcism), 8 studies; 4) evil spirits, 7 studies; 5) cosmic (including fate/predestination, unfavorable horoscope, evil done in previous life, imbalance of Yin and Yang, and planetary influences), 5 studies; 6) lack of or misguided faith, 4 studies; 7) ancestors (communication from and angering ancestors), 3 studies; and 8) unspecified, 2 studies. Two studies (Furnham, Rajaa, & Khanb, 2008; Milstein, Midlarsky, Link, Raue, & Bruce, 2000) had an unspecified causal attribution and only stated that the causal attributions were supernatural in nature.

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The most frequent causal attributions from the public perspective were sorcery/witchcraft, punishment from God, and possession. The most frequent causal attribution from the family perspective was sorcery/witchcraft. The most frequent causal attributions from healer's perspective were sorcery/witchcraft, evil spirits, and ancestors. The most frequent causal attributions from Christians were possession and lack of/or misguided faith. Most studies found evidence for religious/supernatural causal attributions for schizophrenia; however, some studies found a lack of evidence for such attributions. Srinivasan and Thara (2001) found that families in India rarely subscribe to a supernatural causal attribution of schizophrenia, and Swami et al. (2008) did not find evidence that the sample of the public had religious or supernatural beliefs about the etiology of schizophrenia.

Coping Behavior

Twelve of the 43 (28%) articles referenced religious or spiritual coping of schizophrenia. Of these 12 studies, religion provided a supportive role in nearly every case. Examples include dealing with illness, coping with stress, comfort, personal relief, resignation/acceptance, and hope. The method of coping included religious or spiritual beliefs, practices, community, and/or undefined. Religious or spiritual beliefs signified that the individual has a belief in a higher being or a sense of being taken care of through religion, referenced by 7 out of 12 (58%) of studies. Religious or spiritual practices refer to actions or behaviors undertaken by an individual, such as prayer or conversing with a religious leader, referenced by 7 out of 12 (58%) of studies. Religious or spiritual community refers to an individual being a part of a group that professes the same religious identity and uses that community for support, referenced by 2 out of 12 (17%) of studies. In the remaining 2 out of 12 (17%) of studies the method of coping was undefined. Coping behavior spanned across various religious affiliations: Catholicism, Protestantism, Judaism, Taoism, Hinduism, Islam, Buddhism, and Native American beliefs.

Many studies noted multiple religious coping strategies. Five articles reference both religious or spiritual beliefs and practices. This concept was illustrated by Kinsella, Anderson, and Anderson (1996) as they quote a participant in their study whose mother has schizophrenia: "I've always had faith in God, that God cared about me. So I always prayed. I always believed that He would hear me, so I never gave up, and that's how I kept going" (pp. 26-27). Two articles reference religious or spiritual beliefs. Pfiffner et al. (2007) illustrated this by quoting a mother of a patient who stated, "during the six years that my son has been ill, my religious belief has always helped me to overcome all my problems" (p. 822).

Every article, except Moller (1999), discussed the benefits that these relatives received from religious or spiritual coping. Moller (1999) interviewed relatives regarding the difficulties of a lack of support from faith communities. Nearly every article viewed religious or spiritual coping in a positive light. Weisman et al. (2003) reported that 40% of their sample made at least one reference to God or religion in discussing their relative's illness. In general, these relatives stated that religion was used in a supportive manner. On the other hand, Magliano et al. (1998) reported that relatives who endorsed using religious coping also reported higher levels of resignation and lower levels of social support.

Engagement and Help-Seeking Behavior

Twelve of the 43 studies (28%) captured the perspective of participants other than actual clients as it related to engagement and help-seeking behavior for schizophrenia. This included beliefs or actions of others that affect one's pursuit or initial engagement of mental health services. The non-client perspectives included relatives in six articles, the general public in three articles, mental health professionals in two articles, and clergy in one article.

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There were no studies in this section that included the perspective of spiritual and traditional healers.

Of these 12 studies, 10 identified sources of help that individuals with schizophrenia could go to for treatment. Such sources included the pursuit of spiritual and/or traditional healers in eight articles and mental health professionals in five articles. Of the eight studies that identified healers as an important source of help, six demonstrated that individuals often sought the help of traditional/spiritual healers before seeking help of mental health professionals (Kulhara, Avasthi, & Sharma, 2000; Motlana, Sokudela, Moraka, Roos, & Snyman, 2004; Pfiffner et al., 2007; Rammohan, Rao, & Subbakrishna, 2002; Rungreangkulkij & Chesla, 2001). These six studies reported from the perspective of relatives of individuals with schizophrenia, all of whom identified spiritual/traditional healers as the primary or initial source of help.

Five of the 12 studies identified mental health professionals as a source of help. Three studies, reporting from the public perspective, preferred mental health professionals (including the use of medication) as the primary source of help for individuals with schizophrenia (De Toledo Piza Peluso & Blay, 2009; Loewenthal & Cinnirella, 1999; Zafar et al., 2008). In addition, two studies, from the perspective of mental health professionals, preferred the use of spiritual/traditional healers (Furnham et al., 2008; Joel et al., 2003). Only one study focused on the perspective of clergy. Of the 12 studies, 9 identified belief structures around engagement and help-seeking behavior that were directly related to spiritual and/or religious conceptions that guided their preference. Hence, differences exist between the perceptions of family perceptions and the public at large regarding the best potential sources of help for patients with schizophrenia.

Treatment Behavior

Fourteen of the 43 studies (33%) captured the perspective of participants other than actual clients as it related to treatment for individuals with schizophrenia. Treatment was defined as a prescribed course of mental health services, including medication for patients diagnosed with schizophrenia. The perspectives of various stakeholders appeared individually and were combined in the reviewed studies, that is, the general public in six articles, spiritual and traditional healers in four articles, mental health professionals in four articles, clergy in three articles, and relatives in one article. Of the 14 studies, 13 made reference to preferred sources of treatment for individuals with schizophrenia. Such sources included traditional and spiritual practices provided by spiritual/traditional/faith healers in eight articles and/or Western treatment methods provided by mental health professionals in five articles. Examples of treatment methods by spiritual/traditional healers included use of alternative medicines, 'dissuading the obsessing spirit of its purpose to do harm,' spiritual cleanses, and communication with ancestral spirits (Furnham & Igboaka, 2007; Furnham & Wong, 2007; Moreira-Almeida & Koss-Chioino, 2009 ; Mzimkulu & Simbayi, 2006; Teuton et al., 2007). In the five articles that preferred treatment methods by mental health providers, services included psychotherapy, medication, and hospitalization (De Toledo Piza Peluso & Blay, 2009; Harland et al., 2009; Kim-Goh, 1993; Milstein et al., 2000; Motlana, et al., 2004). However, Peluso and Blay (2009) found that medical treatment (with the exception of natural remedies), hospitalization, and ECT were seen as more harmful than beneficial, even though psychological therapy was most valued as a form of treatment.

In addition, studies highlighted the complementary use of both spiritual/traditional practices and more Western psychiatric treatment methods, specifically, adherence to medication (Kim-Goh, 1993; Motlana et al., 2004). In 10 of the 14 studies, it was observed that service providers' preference for a treatment method was notably influenced by their spiritual and religious belief systems. For example, Hartog and Gow (2005) observed that religious

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beliefs and values functioned as significant predictors of the attribution of the causes and treatment of schizophrenia to religious factors.

Discussion

Research on religion and schizophrenia, specifically from family members, professionals, and the larger public have increased over the last three decades. The available research provides a cross-section of international studies from diverse religious and spiritual perspectives. This review found that the religious and spiritual perceptions of families, professionals, and the public are an environmental predictor of coping, engagement, and treatment of schizophrenia. In general, the religious perceptions of families, professionals, and the public regarding coping behavior, engagement and help seeking behavior, and treatment behavior for individuals diagnosed with schizophrenia were reported to have a positive impact; however, the reports were mixed in regard the effect of religious/spiritual notions and etiology.

Overwhelmingly, religion is associated with schizophrenia etiology from the perspectives of concerned others. Religious notions of etiology from non-patient perspectives require further exploration, as there is a high prevalence of religiously themed perceptions of etiology regarding schizophrenia spectrum disorders. Better understanding of the impact of this perspective could aid in improving treatment adherence as the belief and attributions shared by others close to patients diagnosed with a schizophrenia spectrum disorder may support or undermine treatment.

The religious dimensions of coping are a prevalent theme in the reviewed studies. Overall, religious coping, be it practices, beliefs, or support derived from the community, appears to be positive support. Mental health care professionals working with individuals with a schizophrenia spectrum disorder and their families may benefit from an examination of this phenomenon and an exploration of its utility in treatment. A substantial number of relatives of individuals with schizophrenia identified spiritual/traditional healers as the primary or initial source of help; whereas, a minority identified mental health professionals as a source of help. Only three of the reviewed studies focused on the perspective of clergy, which is notable given that this is a review of studies pertaining to religion. The perspectives of interested parties in the treatment of individuals with schizophrenia appear somewhat unorthodox, with marked support for alternative treatments. The notion that conventional medical treatments (with the exception of natural remedies) as being more harmful than beneficial appeared several times. This review suggests that belief structures around engagement and help-seeking behavior may be strongly related to religious conceptions. Furthermore, these religious conceptions may guide treatment preferences. It was also observed that service providers' preference for a treatment method was notably influenced by their spiritual and religious belief systems. Mental health care professionals need not only to be aware of the impact of their own belief structures, but must also actively assess the influence of the beliefs held by others close to patients diagnosed with a schizophrenia spectrum disorder. Nonadherence to treatment may be an unintended consequence of avoiding this dialogue with patients and their supports.

The association of religion and support of family members, mental health and health care professionals, and the larger public remains under-researched. Furthermore, the methodological quality of studies in this area has only marginally improved over the last three decades. The next step in the explication and development of this area of research may necessitate incorporation of more sophisticated methodological approaches. The development of partnerships with clergy and faith-based community organizations may

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provide the needed foundation for testing of religious and spiritually informed interventions and treatment.

Limitations in this investigation include the reliance on published, peer-reviewed English language journals, which consequently limits its analysis to these studies. Also, the methodological caliber and quality of the existing literature, such as the absence of longitudinal studies or randomized controlled trials, is a limitation. Many of the studies focus on beliefs that are less mainstream (e. g., sorcery and witchcraft), and this may further limit the generalizablity of findings. Moreover, a note of caution is warranted since this study reports overall findings across different countries and cultures; thus the reader must bear in mind that cultural differences exist in the practice and conceptualization of religion and matters of faith.

Conclusion

The treatment implications of religiosity and social support from family members, mental health and health care professionals, and the larger public is an under-investigated area of mental health research that warrants further study. Etiological perceptions regarding schizophrenia among professionals, religious leaders, families, and the public are affected by religious themes. In this review, these themes were positively associated with coping, treatment engagement and help-seeking behavior. Individual religiosity of professionals, religious leaders, and families, and the public’s understanding of schizophrenia were found to interact with the treatment of schizophrenia. Enhancing treatment providers’ awareness of this interaction could improve treatment outcomes.

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Note. Asterisks identify studies that were included in the review.

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