The Role of Religious Values and Beliefs in Shaping Mental Health and Disorders

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Abstract: Mental health is an area of continuous analysis, both in the context of understanding increasingly precise diagnostic criteria and the impact of therapeutic methods. In addition to these well-established directions of analysis and search, psychology tries to explore the factors that bring us closer to understanding the mechanisms of the genesis and development of disorders, as well as their importance in psychoeducation or therapy. The increased interest in issues of spirituality/religion observed in recent years translates into the pursuit to explore the relationship between religion/spirituality and health. This article reviews research into the ability of religion and spirituality to benefit or harm the mental health of believers. We also examine the mechanism of developing religious delusions in schizophrenia. Religion and spirituality can promote or damage mental health. This potential demands an increased awareness of religious matters by mental health practitioners, as well as ongoing attention in clinical psychology research.

1. Introduction

For centuries, religion, piety, and spirituality have been the central point of human life closely linked to history and culture. In many cases, religion is the foundation of culture. It builds national identity and creates a sense of community. Religious behavior, such as participation in religious services, pilgrimage, fasting, prayer, and related aspects of spirituality—including trust in God and sense of support of or a bond with a higher transcendental being—positively affect the meaning of life. They also build hope, shape a positive mindset, and help to build inner peace (Marashian and Esmaili 2012).

There are similarities between religiosity and spirituality, but also differences (Boczkowska and Zięba 2016; Iddagoda and Opatha 2017). The researchers define religiosity as the extent to which a particular person believes in and venerates the founder, gods, or goddesses of the relevant religion; practices the relevant teaching; and participates in the relevant activities. Religiosity involves being religious earnestly and genuinely rather than frivolously and nominally. Religiosity is also known as religiousness (King and Williamson 2005; Sedikides and Gebauer 2010; Iddagoda and Opatha 2017). Spirituality appears to mean different things to different people, and its distinction from 'religion' is not clear. For many, spirituality refers to an individual's attempt to find meaning in life, which can include a sense of involvement with the transcendent outside institutional boundaries (D'Souza and George 2006). Religion tends to refer to aspects of belief and behavior, including spirituality, that is related to the sacred or supernatural grounded in a religious community or tradition. Most of the research in this area to date has focused on measuring religiosity rather than spirituality (Williams and Sternthal 2007).

Giving meaning to life and value-based goals, combined with the sense of divine presence when solving one's problems, helps people cope with crises and everyday burdens

(Yang and Mao 2007). In the face of a crisis, many people look for help, first and foremost, in faith, religious practices, and contact with clergy. However, research shows that the role of faith and spirituality is often minimized or even pathologized by professionals (Szafrański 2015). It is difficult not to notice, however, that such an approach has its origin in a culture where religion-related issues are often treated as non-measurable and unobservable, whereas science and medicine hyperbolize pharmacology and pharmacotherapy. In social perception, this translates into mythological expectations that treatment is a saving act, whereas religion, pushed into a margin, becomes faith in miracles and the impossible. In addition, ongoing scientific discussions and studies explore various links between religiosity, health, and disease.

There is a strong association (positive and negative) between religiosity and spirituality and mental health. It has been a sensitive and contentious issue within psychiatry and clinical psychology, dating to Freud as a historical point of view. The weight of evidence, on average and across studies, suggests that religiosity—however assessed—is generally a protective factor for mental illness (Levin 2010). Despite these positive aspects of religiosity and spirituality, there is a growing body of research demonstrating a negative aspect of religion, where religiously-based struggles can be a source of distress for many. This dual nature of religion and spirituality requires an increased awareness of the religious aspects in the psychiatric patients' lives both as protective and risk factors (Weber and Pargament 2014). Negative religion–health relationship is especially visible with regard to schizophrenia due to similarities between religious experiences and psychotic episodes. Religious experiences often include auditory and/or visual hallucinations, whereas people suffering from schizophrenia often report similar hallucinations. Those are accompanied by different beliefs commonly considered to be delusional (such as the belief that they are divine beings, prophets, or that God is talking to them, or that they are possessed by demons, etc.) (Murray et al. 2012). While religion has a protective effect on many mental disorders, religious involvement can become a risk factor in schizophrenia. This article discusses, on the one hand, the role of religion and personal beliefs in shaping the active and adaptive ability to cope with mental problems. On the other, it attempts to show, using schizophrenia as an example, how religious involvement can become a trigger for psychological symptoms. This is because a person's rational thinking is challenged to accept the imperceptible and requires a change in the line of thinking, which in turn may lead to psychotic episodes (Mohr and Huguelet 2004).

It seems that no disorder other than schizophrenia encompasses both religious and scientific threads that penetrate but also disregard and avoid each other (Sass 1994; Mohr and Huguelet 2004; Borras et al. 2007). According to the APA Dictionary of Psychology (VandenBos 2007, p. 815) "schizophrenia is a psychotic disorder characterized by disturbances in thinking (cognition), emotional responsiveness, and behavior. Schizophrenia is still one of the most mysterious mental disorders that are characterized by delusions, hallucinations, and impaired social behavior." A similar definition can be found in Merriam-Webster Dictionary. Schizophrenia is defined there as "a mental illness that is characterized by disturbances in thought (such as delusions), perception (such as hallucinations), and behavior (such as disorganized speech or catatonic behavior), by a loss of emotional responsiveness and extreme apathy, and by noticeable deterioration in the level of functioning in everyday life" (https://www.merriam-webster.com/dictionary/schizophrenia, accessed on 9 August 2021). Schizophrenia is presented as a medical term and more particularly as a psychiatric concept. Research on schizophrenia also shows that religiosity and spirituality are of particular importance to many patients and usually play a positive role, which means better coping with psychosis, giving it meaning and sense (Mohr and Huguelet 2004; Borras et al. 2007; Szafrański 2015).

The literature search procedure for this review involved systematic searches of title and abstract fields through online databases (i.e., EBSCOhost, PROQUEST, Medline, PsychInfo, Google Scholar, and Google Books). As much of the relevant literature is somewhat dated and limited, there were no restrictions imposed on the date of publication. A combination

of the following terms was used: religiosity and mental health, spiritual psychosis, spiritual activity, religious delusions, spiritual struggle, psychological crisis, schizophrenia, religion, religious practices, and spirituality. These terms were used in different combinations and all the relevant articles were identified. The reference lists of relevant papers and book chapters were also perused to aid the identification of additional relevant references.

This article focuses on the relationship between religiosity, spirituality, and mental health in the context of both, positive and negative associations. An overview of the theoretical thesis and empirical evidence is presented linking the extent of spirituality or religious involvement to health and mental disorders, with an emphasis on schizophrenia analysis and studies. The psychological mechanism underlying the relationship between religiosity and mental health is outlined, as well as some of the challenges in this area and priorities for practice. That is why the authors refer to contemporary knowledge about the factors and mechanisms related to mental health, recovery, and etiology of delusions in schizophrenia. They also discuss the understanding and application of treatment to improve the health and quality of life of patients and their families. The article reviews the evidence and explores the impact that some expressions of spirituality can have, as part of an integrative approach, on understanding mental health forming a risk factor in people prone to developing psychotic disorders.

2. The Relation between Religiosity and Mental Health

Over the last few decades, increased emphasis on the holistic understanding of a human being has paved the way for research into the relationship between religiosity, spirituality, and human mental health (O'Reilly 2004). This association, common in eastern cultures, is being duly recognized in Western Europe only now (King 1998; Janus 2004; Sieradzan 2005, 2015). Religiosity (understood as belonging to a specific church, participation in religious services) and spirituality (understood as a connection with a source greater than self, a sense of transcendence) are important aspects of the everyday life of many people.

The relationship between religiosity and mental health can cover two domains (positive/negative) and five main forms. These relationships apply to both healthy people and patients with mental disorders. Religiosity can (1) be an expressive outlet for present psychological problems and mental disorders, (2) allow escape or soothe given life problems that underlie the disorder, (3) inhibit symptoms and foster socialization, (4) provide an opportunity to constructively cope with stress and problems, and (5) contribute to the worsening of symptoms and development of disorders. All these relationships also apply to schizophrenia. Studies on schizophrenia also show that religion and spirituality are of particular importance to many patients and usually play a positive role, which means better coping with psychosis, as well as giving it meaning and sense (Szafrański 2015). Suzanne Heffernana et al. (2016) point out the positive effects the scriptures can have in a schizophrenia patient's life. In religion, patients found advice on how to cope with difficulties in life and how to be a better person. Exemplary in helping others, it reinforced their belief that they were being helpful to society.

3. The Positive Links between Religiosity and Health

The reviews continue to provide further evidence of an association between religious involvement and health. Religion-associated variables have been shown to have protective effects for multiple mental health outcomes, including wellbeing, relieving mental symptoms, suicidal behavior, and substance misuse (Williams and Sternthal 2007).

3.1. Religiousness as a Way to Relieve Tension Related to Mental Health Problems

The studies have shown that 59% of people worldwide consider themselves to be religious, regardless of whether they regularly attend services (WIN-Gallup 2012). The search for links between spirituality and mental health is explored in many ways. Research, conducted across many scientific disciplines, focuses on several important directions,

including interdependency, seeking evidence of how religiousness contributes to health, mental disorders, or recovery (Nicholls 2002; Foskett et al. 2004; Barker and Buchanan-Barker 2005). Initially, there was a tendency in scientific literature to seek a straight-line relationship between certain spiritual manifestations and the narrowly defined aspects of mental health. Emphasis is placed on an integrated approach that assumes two-way, interactive, and impact-prone correlations (Cornah 2006). Research confirms the positive impact of faith and religiosity on the patients' recovery from both somatic (Jim et al. 2015) and mental illnesses (Lukoff 2007). Relevant correlations have also been shown concerning mental health in the following aspects: a sense of well-being (Pargament et al. 2013), level of security (McCullogh and Willoughby 2009), the experience of positive emotions (Abu-Raiya and Agbaria 2016), or lower levels of anxiety and sadness (Hood et al. 2009).

3.2. Religiosity Is a Form of Escape or Soothes Given Life Problems

Religion can have a significant impact on the way a person lives and experiences life. A religious person may find several areas in life to be at least somewhat influenced by their beliefs. Many people find their religious faith to be a source of comfort and solace. They may find that believing in a higher power gives their life meaning and provides them with a set of standards or moral codes to live by. Religious faith may make it easier for some to cope with challenges in life and practice compassion toward others. A review of 3300 studies showed that religiosity can lead to better mental health, increased adaptability to problems, and a lower risk for physical problems. For many individuals, religious beliefs have the potential to reduce stress, increase positive emotions, give meaning to adversity, and enhance one's sense of purpose (Koenig 2012).

A meta-analysis of 17 studies showed that religious attendance and intrinsic (internalized) religion tend to be associated with reduced anxiety (Shreve-Neiger and Edelstein 2004). Another meta-analysis revealed that positive forms of religious coping were related to lower levels of depression, anxiety, and distress, which is connected with psychological adjustment (Ano and Vasconcelles 2005). Religiosity plays a positive role for adolescents, too. Studies of adolescent behavior have found that higher levels of religious involvement are inversely related to alcohol and drug use, smoking, sexual activity, depressive symptoms, and suicide risk (Rew and Wong 2006).

3.3. The Role of Religiosity in Inhibiting Symptoms and Fostering Socialization

The essence of the behavioral concept is to treat religion as one of many social human behaviors, shaped in the process of socialization and education (Zimnicka-Kuzioła 2012). Health practices and social ties are important pathways by which religion can affect health. Other potential pathways include the provision of systems of meaning and feelings of strength to cope with stress and adversity. Both Aaron Beck and Albert Ellis criticized religion in their early works (Sikora 2019). As K. Sikora (2019) points out, Ellis' radical views on religion were based on his personal convictions—i.e., identifying religion with an oppressive system of irrational beliefs and mental imbalance. While he considered the concept of sin to be a source of psychological distress, he also rejected the inclusion of religion in a psychotherapy process and even the possibility for therapists to profess any religion. However, the development of the cognitive behavioral approach and the strengthening of Wells' metacognitive approach (Wells 2010, 2011) have led to the recognition of the role of key and early-childhood experiences in the formation of cognitive schemas, in particular the self-schemas (Young et al. 2019). As highlighted by K. Sikora (2019), the adopted theoretical assumptions allowed for the development of religious/spiritual cognitive behavioral therapies (R/S CBT). The empirical support for R/S CBT has yielded mixed results. A meta-analysis of 31 outcome studies of spiritual therapies showed empirical evidence that spiritual-oriented intervention may be beneficial to individuals with psychological problems of depression, anxiety, stress, and eating disorders (Smith et al. 2007). Although the evidence for the efficacy of R/S CBT with schizophrenia is limited, Tabak and Weisman de Mamani (Tabak and Mamani 2014) suggested that cognitive restructuring could perhaps

be useful in addressing meaning-making and improving the quality of life in patients with schizophrenia. However, the authors suggested that this would be more applicable to patients in recovery. They caution about generalizing the issue when discussing it with individuals in acute stages of schizophrenia or with severe symptoms.

3.4. Religious Involvement as a Coping Behavior

In many countries, researchers systematically report that the use of religious and spiritual involvement as a coping strategy is widespread. In the years following the events of 11 September, 2001, in the US, 90% of Americans managed to cope with stress by turning to religion (Schuster et al. 2001). Psychiatric patients also often use religion to cope. A survey of 406 patients with chronic mental illness revealed that, for as many as 80% of them, religion helped to cope with the effects of the disorder (Tepper et al. 2001). Other studies showed that 79% of psychiatric patients stressed the importance of religion in their life, 67% stated that spirituality helps them cope with mental problems, and 82% believed that the therapist should be aware of their religious and spiritual needs (D'Souza 2002). Why religion, as a coping mechanism, is so common among patients with mental disorders? Harol Koenig (2009) points to several important arguments. Firstly, religious beliefs provide sense and purpose in difficult life circumstances, which helps to integrate the psyche. Religious beliefs tend to be based on a positive world view that is, in principle, optimistic. Religious beliefs justify suffering and fate, whereas saints and church fathers act as role models in the Scripture, thus facilitating acceptance of suffering. Secondly, spirituality and religiousness give people a sense of at least indirect control of the circumstances, reducing the sense of helplessness. Thirdly, religions offer a community of support, both at the spiritual (divine) level and the human level. Each of these types of support is effective and helps reduce loneliness and isolation. Ultimately, unlike many other means of coping, religion is available to anyone at any time, regardless of financial, social, physical, or external circumstances.

Studies on schizophrenia also show that religion and spirituality are of particular importance to many patients by playing usually a positive role. This means better coping with psychosis, giving it meaning and sense (Szafrański 2015; Żechowski 2015).

4. Factors Affecting the Relationship of Religiosity and Mental Health

Some of the studies investigating the relationship between spirituality and mental health try to understand the mechanisms underlying the positive impact of religious activity on mental health. Instead of assuming that the value and spirituality or religious commitment does not reflect the divine intervention, the researchers consider other factors that may explain the relationships.

4.1. The Specificity of Religious Involvement and Mental Health

A research review by Bergin (1991) and the Payne team (Payne I. Reed et al. 1991) concerning the relationship between religiousness and mental health provided mixed results. It turned out that there are several links between different types of religious activity and positive mental performance, but the results obtained were not very spectacular. In addition, religiosity was positively linked to many measures of mental well-being. However, no general evidence was found on the link between religiousness and the prevention of mental/fundamental disorders. The researchers concluded that the ambiguity of the results obtained was due to the misconception of "religiousness", which due to its multidimensional nature should not be considered uniform. They pointed out that, for mental health, it is not important how deeply religious a person is, but what is the form of religiosity (Hackney and Sanders 2003).

A detailed analysis of the relationships between the specificity of religious involvement, mental health, and positive adaptation confirms the above assumptions. The strongest positive ties were shown for personal involvement in religious practices. Weaker correlations were related to the professed ideology, and the weakest and exclusively neg-

ative were linked to institutional religiousness (Hackney and Sanders 2003). Theoretical explanations of these relationships are sought in Greenberg's terror management theory (Greenberg et al. 1991) and the concept of self-determination (Deci and Ryan 1985). The first one is based on the assumption that the experience of terror is the basic source of human motivation and certain beliefs resulting from the awareness of unavoidable death. In this context, participation in religion (understood as an institutional manifestation of a common view of the world) protects individuals from existential anxiety and enables them to achieve a sense of their self-value and (probably) satisfaction with life by knowing that it is an important part of the meaningful universe. However, research indicates that being a mere member of a church community is not enough. For good mental performance, it is essential to be a "true believer", who authenticates the system of religious beliefs and puts them into practice (Hackney and Sanders 2003). The second concept sees the human being as an active organism with the potential to act. The sources of human potential are located both inside individuals (such as drives, emotions) and in the environment in which they operate. This theory describes a human being as a self-regulating system capable of self-development and integrating their actions. The coherence of this system contributes to the achievement of well-being (Ryan and Deci 2001).

The work of Ryan et al. (1993) provides examples of religious internalization. The researchers focus on two types: introjected (the individual's involvement in religion is based on self-esteem and affective conditions) and identified (the individual's involvement in religion is based on personally selected and valued convictions). The research results, at least in part, confirm the relationship between internal, adopted value-based motivation, and subjective wellbeing (Deci and Ryan 1985; Nix et al. 1999). The results confirm that the more internalized the motivational style is, the higher the mental health level of the individual. Thus, the link between religion and mental health can be considered stronger, since both phenomena (religiousness and mental health) are based on similar mechanisms, and are consequently applied in a specific, introjected way.

4.2. Religiosity as a Form of Attachment

The search for psychological mechanisms underlying the relationship between religious involvement and mental health shows several psychological processes, such as coping styles, sense of control, social support, and social networks (Cornah 2006). The role of physiological processes involved in mental health building (Larson and Larson 1998) is also emphasized. Research by Granqvist (2005) and Kirkpatrick (2005) shows that the relationship of a person believing in "God" meets three criteria of the attachment relationship, namely: (1) searching for and maintaining closeness; (2) searching for the so-called safe haven at the moment of stress (hiding, protection, safety); and (3) using "stronger and more powerful" as a secure base when testing the reality. Such an understanding leads toward attachment theories, which in psychology are important for building relationships and self-understanding.

The way we communicate with other people, including our children, has a huge impact on their development (Siegel and Hartzell 2015). Human beings, as social beings, require a two-way emotional dialogue, which strengthens our sense of security by helping us to cope with the challenges in many areas of life. The theory behind this phenomenon is the concept of attachment which explains the need for intimacy with another person, including God. The concept of the omnipresent God provides a sense of closeness, which brings a feeling of comfort, support, trust, and hope while reducing tension and anxiety in stress and risk situations. Thus, according to Kirkpatrick (2005), people project onto God the internalized relationship with an attachment figure, a kind of model of relations with important people. These patterns are formed in human life mainly based on ties with parents. In this sense, in the context of the attachment theory, the relationship with God can be treated in the same way as an internalized relationship with a human being, and the figure of God can be treated as an attachment figure (Żechowski 2015). In turn, according to Mario Mikulincer and Phillip Mikulincer and Shaver (2010), the development

of a religious, spiritual, or philosophical approach to life is one of the important indicators of human maturity. The concept of the omnipresent God provides a sense of closeness to an object and provides a feeling of comfort, support, trust, hope, and reduces tension and anxiety in stressful and risky situations. According to Mikulincer and Shaver (2010), the spiritual nature of people with a trusting, safe style of attachment is based on cognitive openness, exploration of vital existential issues, individual development, and autonomous reflection. Such attitude toward inner life takes into account the ambiguity, uncertainty and the ability to eliminate some degree of confusion associated with religious development. In turn, people with an impaired feeling of safety—i.e., with the so-called mistrust patterns of attachment direct their frustrated attachment needs to God. In their case, God is an alternative form of attachment that is intended to compensate for the failed relations and ties, and consequently to lessen the fear experienced in relations (theory of compensation) (Kirkpatrick 2005).

In his theoretical article, C. Żechowski (2015, p. 11) emphasizes that "people with mistrust attachment use spirituality to build a system of defense against frustration and pain, completely different from trusting people whose spirituality ties in with an exploration of reality and development." When citing John Steiner's views (2010), he describes the specific way in which the mind works, which Steiner calls a psychic retreat. In other words, individuals develop a complex system of defense, which allows them to avoid contact with another person and reality and shelter themselves in a fantasy world. These defenses, on one hand, foster a sense of security, and on the other, block development and detain individuals in the world of illusion and transitional facilities.

In addition, distrustful people may project their insecurity onto God. This issue has been best described in Polish literature by C. Żechowski who presents skeptical people as those for whom God is a dismissing, angry, or judgmental figure who demands obedience and being pleased (Mikulincer and Shaver 2010; after Żechowski 2015). In addition, other attachment styles present specific relationships with God and attitudes to religion. In the case of an anxiety attachment, individuals are not sure of God's love, while in the case of avoidance attachment, they try to maintain distance and independence. Those with a disturbed sense of security, in turn, experience considerable difficulties when seeking and discussing religious attitudes (Żechowski 2015). People with a disturbed sense of security are more likely to succumb to fundamentalism and dogmatism, which can activate strong emotions, trigger an illusory experience of life or separation from reality. In contrast, people with a distrustful attachment style present a high number of sudden conversions, more frequent interest in New Age practices, spiritualism, esoterism, a "new birth" experience. In addition, distrustful persons experience sudden emotional changes while using religion to distance themselves from parents and compensate for the sense of insecurity and crises experienced (Żechowski 2015).

Numerous studies have shown that insecure attachment styles, especially disorganized attachment, can be an important risk factor for mental disorders (Green and Goldwyn 2002). Research on attachment in schizophrenia showed that avoidant and disorganized styles are the most common (Tyrrell et al. 1999; Berry et al. 2007) and that the separation from the mother in the first two years of life is a significant risk for developing schizotypal symptoms (Anglin et al. 2008; Gabino et al. 2018). Dissociation, changed state of consciousness, de-recognition, and de-personalization are the common features that characterize people with a disorganized attachment style (Granqvist et al. 2012).

5. Negative Effects of Religiosity

However, the role of spirituality and religiosity in the context of mental health is not always based on positive impact. While for some people religious affiliation is helpful and assists the recovery process, in other cases it may pose a risk factor because it leads to excessive blame, shame, and feeling of abandonment (Faiver et al. 2011). Research has shown that feelings of religious guilt and the failure to meet religious expectations or cope with religious fears can contribute to illness (Trenholm et al. 1998). People who manifest

a greater extrinsic religious and spiritual orientation (i.e., use their religion for nonreligious or antireligious purposes) report lower wellbeing (Abu-Raiya 2013). Malinakova et al. (2020) assess the associations of religiosity measured more specifically, with mental health in a secular environment, using a nationally representative sample of Czech adults (n = 1795). They found that, compared to stable non-religious respondents, unstable non-religious and converted respondents who perceived God as distant were more likely to experience anxiety in close relationships, and had higher risks of worse mental health.

Negative aspects of religiosity refer to such processes and mechanisms as negative beliefs and negative religious coping. Negative beliefs can mean negative or punitive images of God, which can increase guilt or lead to discouragement as they fail to live up to the standards of their faith tradition (Bonelli et al. 2012). It can turn religiosity from a potential resource into a source of spiritual struggle as a risk of depression, anxiety, paranoia, obsession, and compulsion (Koohsar and Bonab 2011). Negative religious coping—referred to as "religious struggle" or "spiritual struggle"—can be categorized into three types: (1) divine, or difficulties and anger with God; (2) interpersonal, or negative encounters with other believers; and (3) intrapsychic, or internal religious guilt and doubt (Weber and Pargament 2014). Each type of religious struggle has been associated with psychological distress as depression (Ramirez et al. 2012), greater frequency and intensity of suicidal ideation (Rosmarin et al. 2013) and more anxiety and grief (Fitchett et al. 2014).

The most negative influence of religion on health can be seen in the case of schizophrenia. For psychotic patients, incorporating religious and spiritual themes into their delusions may lead to greater conviction in delusional beliefs, greater severity of symptoms, and lower levels of functioning, as well as less compliance with psychiatric treatment (Siddle et al. 2002; Mohr et al. 2011).

5.1. The Nature of Schizophrenia in the Context of Religiosity

Schizophrenia is a mental disorder of a psychotic nature. This type of disorder is characterized by an affected, inappropriately perceived, deeply experienced reality. A person suffering from psychosis has a severely impaired ability to critically and realistically assess self, the environment and relations with others, and is not even able to do so. Schizophrenia is a mental disorder with a multitude of symptoms. To simplify the understanding of the disease, clinical literature often groups the symptoms into positive and negative ones. Positive or negative symptoms do not mean a "positive" or "negative" impact on the outline and course of schizophrenia. They indicate certain "excess" of experience, thoughts or "absence/shortage" in perceiving or experiencing reality and in terms of convictions.

Many psychotic patients experience religious delusions, some of which are difficult to distinguish from so-called 'normal' religious or spiritual beliefs. About 25% to 39% of schizophrenia psychotic patients and 15% to 22% of bipolar patients experience religious delusions (Koenig 2011). As noted by D. Janus (2004), a person believing themselves to be a prophet, a messiah or a God became a symbol of psychopathology. Grandiose and religious delusions are common in schizophrenia, which is combined with an extraordinarily high status in the patient's mind. However, it should be noted that this picture tends to fluctuate, and only occasionally the patients are convinced of their unlimited powers, which can be identified with the figure of God. Grandiose delusions, which most often take the form of religious delusions, are a unique compromise between isolation and living with people. Figures such as a ruler, dictator, or messiah are both different and alienated. In other words, a schizophrenic person cannot live with people, but also, as a human being, cannot live without them. To maintain valuable isolation and, at the same time, contact with other people, patients appear as someone surpassing others, while at the same time having something precious for them. By becoming a "God", a schizophrenic is freed from the embarrassing influence of the past, childhood, and family, gets rid of a family- and socially dependent sense of guilt, which is one of the factors that limit their freedom of self. Just as the cultural image of God is created by eliminating parents, so does the schizophrenic patient, to get away from them, become God.

Interestingly, our clinical studies (Pastwa-Wojciechowska, Grzegorzewska, Wojciechowska, in progress) of the people in the care of the community assistant (N = 12) showed a very frequent family pattern. As children, they were being entrusted to the care of their grandmothers, who were extremely religious persons. This was followed by the family breakdown (divorce of parents), most often caused by the use of alcohol by the father or both parents. Patients developed symptoms during childhood or adolescence, whereas religious content and association with religious practices were particularly important for them translating into delusions. In addition, D. Janus (2004) emphasizes that patients identify themselves not as much with the figure of Christ as a whole, but with individual aspects of that character or its incarnation: a suffering man (most often) or an adored Child, omnipresent Creator and savior or a silent, helpless Lamb of God, or even—as in the case of their patient—a sensual, naked symbol of excellence and beauty. The early "selection" of a given image of Christ reflects the structure of the individual's self as it represents conflicts and developmental deficiencies that seek solutions and satisfaction, respectively.

In turn, when referring to the literature on the subject, it should be noted that, in the case of schizophrenia patients, the most frequent delusions were those regarding hearing the voice of God or other hallucinations attributed to God or Satan, including a conviction to be God, Jesus, or an angel or a conviction to be possessed by devil or demons (Persaud 2006; Sieradzan 2015). In addition, it was stated that: (a) the content of the delusions reflects the local religious/cultural environment, (b) the religious symptoms are a significant minority among psychotic symptoms, and (c) the psychosis, instead of pointing to a link to a specific religion, may precede a change of religious affiliation to a less traditional ("orthodox") faith (Sieradzan 2015). On the other hand, other studies show that religious delusions are not a uniform phenomenon, with a common neurocognitive or neurobiological basis. They should be placed in the context of life history and environmental factors, therefore they should not be considered as a distinct group of delusions (so-called religious delusions) (Sieradzan 2015).

5.2. The Role of Religion in the Genesis of Schizophrenia

To understand the link between religion, spirituality and pathological psychosis, it is important to see the role that religion plays in the origin of schizophrenia. First, it is crucial to appreciate the religious involvement in the standard population. For example, according to the Gallup Poll study, 73% of US respondents were "convinced God exists" and another 19% indicated that God "probably exists". In contrast, 3% said they were convinced that God does not exist. Furthermore, 4% claimed that God probably does not exist, but they are not sure (Newport 2006). In Polish surveys, 95% of respondents indicated being believers, of which every eighth (13%) described their faith as deep. More than half of respondents (54%) take part in religious practices at least once a week, and one in every 20 (5%) people do so several times a week. The perception of religious faith in terms of the factors that makes life meaningful depends on the involvement in religious practices. Of those who participate in religious rites more often than once a week, the belief that faith makes life meaningful is expressed by 57% of respondents and only 5% among those that do not practice at all. Furthermore, religious faith in the context of life meaningfulness is more likely indicated by respondents who are older, poorly educated, disadvantaged, pensioners, and rural dwellers. They are also more often women than men (CBOS 2009). Religious involvement increases in situations of danger to life or health. In a situation of severe stress, religious rituals are often used to cope with or adapt to difficult, unfavorable circumstances: people call for God's help, pray, commit to service or seek consolation in religious communities. For example, 90% of Americans turned to religion as a way of coping with the terrorist attacks that took place on 11 September, 2001, in New York City (Schuster et al. 2001). It is therefore not surprising that many psychotic patients are religious, more or less involved in the spiritual development and life of their church. People with schizophrenia have the same spiritual needs as other people, but their susceptibility to religious content is different.

Patients with schizophrenia are particularly sensitive to stress (Mohr 2006). This sensitivity builds their vulnerability to religious delusions (Koenig 2007). Religious delusions exist on a continuum between the normal beliefs of healthy individuals and the fantastic beliefs of psychotic patients. Psychotic patients usually experience religious delusions together with other mental symptoms and behaviors and these delusions do not appear to serve any positive function (Siddle et al. 2002). The Siddle team (Siddle et al. 2002) reports a positive correlation between religious delusions and religious activity in 193 inpatients with schizophrenia. Patients with religious delusions scored significantly higher on self-assessed religiosity and doctrinal orthodoxy than those without religious delusions. The mechanism linking religious involvement and the genesis of psychosis has not been fully recognized.

It is pointed out, however, that religious conversion (irrespective of the particular religious group) may be associated with or result from the psychosis etiology (Koenig 2007). Much depends on the speed of the conversion. As indicated by Wootton and Allen (1983), a sudden conversion could be more the cause or consequence of a developing disorder than a slow one, which is based on spiritual reflection of the conversion. It is also pointed out that religious conversion can often occur during an emotional shock or mental stress, which further strengthens susceptibility to delusions.

The delusions may also be not so much the cause but the consequence of the conversion. Studies conducted in India have found that 22% to 27% of patients with schizophrenia report an increase in religious activity following their diagnosis (Bhugra et al. 1999). This may reflect an increased turning to religion to cope with the stress of schizophrenic symptoms in a highly religious population. A further study showed that many psychotic people changed to a new religion after the diagnosis of schizophrenia. The researchers suggested that this recurrence was at least partly an attempt to regain self-control because their image began to change with the appearance of schizophrenic symptoms (Bhugra 2002). In this study, it was clear that religious conversion was second to psychotic development rather than vice versa.

5.3. The Role of Religion in the Manifestation of the Symptoms of Schizophrenia

Distinguishing deep religious involvement from religious psychotic symptoms is not easy. The mechanisms behind the psychotic symptoms formed in the context of religious involvement are not fully known. Religious delusions occur in up to 25% of persons with psychosis and may be used to determine whether psychosis is present (Koenig 2007). Thus, distinguishing religious beliefs and psychotic experiences become an urgent dilemma for clinicians.

The literature presents several criteria that distinguish between pathological and non-pathological religious involvement (Pierre 2001; Lukoff 1985; Sims 1995). Firstly, for religiosity to be considered pathological, it must affect the ability of a person to function by impairing work performance, legal problems, unstable behavior, increased aggression, neglecting daily duties, or experiencing problems when testing reality. Secondly, a person with pathological religious involvement lacks mental maturity or spiritual development. Thirdly, psychotic persons usually have no insight into the unrealistic nature of their religious beliefs. They can even strengthen or embellish the beliefs. Furthermore, the psychotic person will experience difficulty establishing "intersubjective reality" with other persons in their psychosocial or religious environment, particularly since they will have other symptoms of psychotic illness that impair their ability to relate to others. Psychotic and spiritual states may overlap. This makes it difficult to distinguish one state from the other without long-term follow-up and observation. Ultimately, psychotic people experience other symptoms that affect their psyche and behavior, such as hallucinations, impaired thinking processes, or mood disorders. Of course, as Koenig (2007) claims, there is always a possibility that a mentally (even psychologically) sick person will have religious beliefs and mystical experiences which are culturally normative and can help that person cope better with mental illness.

5.4. The Roots of Religious Delusions in Schizophrenia

As previously noted, religiousness and spirituality play a special role in psychotic disorders. Several well-known researchers—such as S. Freud, E. Fromm, R. May, or A. Lowen—believe that Western culture is schizophrenic, meaning that the Western culture makes us more vulnerable to mental problems (Sieradzan 2008). Already in the mid-19th century, psychiatrists considered madness to be the price paid for the development of civilization (Sieradzan 2005, 2015). Transcultural research conducted by 40 psychiatrists in the early 1960s in 27 countries across the world showed that religious hallucinations are the most common among Christians. However, it should be noted that nowadays there are so many people with mental problems that Robin Persaud (2006) introduced a new category of "people with poor mental health" and presented the problem of religiosity as one of both driving and retarding forces of our life.

From a historical point of view, religious issues are mainly reflected in the psychoanalytical paradigm, as referred to by Freud—but also Jung, Fromm, and Erikson. Carl Gustav Jung (1997, 2015, 2017) introduced the concept of archetypes—symbols constituting the content of the collective unconscious, a product of the earliest experiences of humanity. Archetypes—i.e., the prototypes of human beliefs, universal models of thinking and actions, deposits of eternal knowledge—are reflected in dreams, myths, religions, and art. From this perspective, God is an archetype, a constant element contained both in the conscious and unconscious sphere of the human psyche. Erich Fromm (1966), in turn, recognizes a human being as a religious person, but interprets religion broadly, as a reference system that provides an individual with an orientation system and an object of worship. According to Fromm, every person needs an ideal and thus an object of adoration. This perspective results from Fromm reflecting Freud's views (Freud 1967) in this respect and assuming that the monotheistic religion stems from a longing for a perfect father, who combines or integrates the elements of good and evil in an individual. In other words, it will both reward and punish, depending on the situation. For most people, however, faith in God means believing in a father who is eager to help—i.e., it is nothing else but a child's illusion. Eric H. Erikson (1997, 2004) highlighted the positive and negative aspects of religion in our development. On one hand, faith allows solving development crises that occur in the life of each person. On the other hand, it can take pathological forms, such as promoting intolerance and hostile attitudes toward those who think differently.

The relation between archetypes and religious delusions in schizophrenia provides a bridge between the healthy and pathological functioning of the psyche. In the light of Jungian theory, acute psychosis is considered to be an eruption of the collective unconscious with the fragmentation and dissociation of a weak, undeveloped conscious personality. The archetypal patterns and images which ordinarily govern life from the depths of the unconscious are suddenly exposed to view becoming part of a disturbed psychotic awareness. As Edinger notes (Edinger 1955, p. 626): "Very often the ego undergoes an inflated identification with a highly charged, numinous archetypal figures, such as the hero or the savior. It is this pattern we see in the frequent cases of delusional identification with Christ, who for Christians (and sometimes unconsciously for Jews) carries the projection of the archetype of the spiritual hero." In this case, the delusion of Jesus as an archetype of god is a form of ego defense mechanisms led by the denial and projection is necessary to such an "ideal" come into consciousness. Religious delusions provide a temporary solution to personal, existential, and metaphysical problems and also relief, meaning, and even joy. Unfortunately, the psychotic symptoms persist.

The search for links between schizophrenia and religion has, in a sense, a well-established position in psychiatric, psychological, philosophical, or social literature. Often in each of the great world religions, people who—according to psychotic nomenclature—have psychotic symptoms are treated either as being gifted with extraordinary powers and knowledge or as being possessed by ghosts or demons (Prusak 2015, 2016). As J. Prusak (2016) emphasizes, guidelines of the American Psychiatric Association and the American Psychological Association require clinicians to make a diagnosis that differentiates between

religious or spiritual problems occurring without a connection with mental disorders and those that either coexist with symptoms of such disorders (but without a causal link) or act as triggering or supporting factors for a given pathology. In either case, code V 62.89 may be used and included in the diagnosis either (a) independently, (b) in addition to the diagnosis of mental disorder, or (c) as part of the diagnosis of the disorder, when its symptoms show religious or spiritual aspects. This clinical approach corresponds to the results of research into the relationship between religion/spirituality and mental health/psychopathology.

S. Dein and R. Littlewood (Littlewood and Dein 2013) link the genealogy of schizophrenia to such factors in Christianity as (1) an omniscient deity, (2) a decontextualized self, (3) ambiguous agency, (4) a downplaying of immediate sensory data, (5) scrutiny of the self, and (6) its reconstitution in conversion. According to Sieradzan (2015), studies showed that one-third of those with diagnosed psychosis with religious delusions live in Western countries. In turn, K. Dyga and R. Stupak (Dyga and Stupak 2018) indicate that the prevalence of such phenomenon among hospitalized patients is the highest in the United States (36%) and the lowest in Pakistan (6%), where a significant proportion of grandiose delusions concerns identification with God, Jesus, or Mahomet. In other studies, the frequency of religious delusions was estimated to be 21% in Germany and 6% in Japan. As Dyga and Stupak stress, cultural and religious differences have an important impact on the existence of specific forms of delusions as well as their image. However, the frequency of delusions related to identifying oneself with Jesus is difficult to quantify, although probably they form a small part of all religious delusions. The religious component can, in principle, include every type of delusion, although most often it happens in the context of grandeur, guilt, persecution, and secondary delusions. More and more often, delusions are considered to be a complex and multidimensional phenomenon. Therefore, the psychological assessment process considers, for example, the number, absorption, omnipresence, distress, and the role of perception, influence on behavior, effectiveness, and strength of belief (Dyga and Stupak 2018).

6. Implications for Practice

In the biopsychosocial model, mental disorders are usually treated with medications, psychological interventions, and familial and social support. However, the model does not take into account the religious dimension of the patient, i.e., spirituality (concerned with the transcendent and questions about life's meaning) and religiousness (concerned with specific behavioral, social, and doctrinal attributes).

For many professionals (psychiatrists, psychologists, nurses), it might be problematic to address religious or spiritual issues when working with patients due to the perceived lack of competence or the rational nature of the so-called professional assistance. However, to understand patients and help them effectively, comprehensive assistance and support should be offered instead of focusing on technical, administrative, isolating, or forced solutions. Unfortunately, such activities are a part of the treatment 'culture' and thus limit the understanding and meaning of religion in the etiology and pathogenesis of disorders, focusing on symptoms and not on understanding that they are an expression of the problems of the suffering person. In addition, they reduce the patient to the system's element, rather than the subject, which in turn causes patients to search for forms of assistance that will allow them to feel the subject of treatment.

Various studies show that spirituality and religion are important aspects of the life of many patients. Their faith and involvement in religious practices are a source of hope and strength in the fight against illness, giving meaning to the illness and, above all, leading to better outcomes of treatment (Dyga and Stupak 2018). In addition, the literature on the subject recommends avoiding confronting patients with their delusions, and instead focusing first on reducing the suffering associated with the delusions and then on the positive aspects of spiritual life. It is also important to remember that patients insist more strongly on religious delusions than any other type, which makes them more challenging in the therapeutic process (Dyga and Stupak 2018).

Interesting research on the role of religion in health recovery was presented by Suzanne Heffernan, Sandra Neil, Yvonne Thomas, and Stephen Weatherhead (Heffernana et al. 2016). The researchers identified eight areas which, in their opinion, explain how religion can affect health recovery—i.e.: (1) use of scriptures and rituals, (2) a genuine connection with God, (3) the struggle to maintain rituals, (4) guidelines for living, (5) choice and control, (6) relating to others, (7) enhancing psychological well-being, and (8) making sense of experiences.

Thus, it turned out that "the use of scriptures and rituals" was important for patients, because they believed that frequent praying could help them recover quicker. In turn, a "genuine connection with God" is important for patients to return to health, while the omission of this aspect has exacerbated their results. In contrast, the "struggle to maintain rituals" indicates that the inability to concentrate during rituals increases patients' tendency to blame themselves for reducing their ties with God, which means becoming a bad person. As a result, the symptoms of some patients may have become more severe. The researchers stress that some patients, despite restrictions in performing rituals, used CDs, for example, to listen to the Word of God.

However, it should also be remembered that religion may also harm the recovery process. 'Guidelines for living' point out that in religion patients found advice on how to cope with life difficulties and how to be a better person. For example, helping others reassured them to believe they were helpful to society. However, some participants noted that such top-down advice may give rise to increased guilt and return to health being more difficult. 'Choice and control' gives patients a sense of agility because they have a sense of choice, that is, they can believe in what they want to believe, not what other people tell them. The personal choice of patient's beliefs was also important when returning to health. In addition, the choice and control were very important for patients to return to their health because, for example, they believed that God had shown them the way, although, ultimately, they helped themselves. Others preferred to externalize control by being "in a world where only God can help you". However, some patients thought that only they could help themselves through hard work.

'Relating to others' showed that religion can strengthen and also hamper ties with others when a psychotic person returned to health. On one hand, patients noticed a sense of belonging to the community, being accepted and helped with illness. On the other hand, some patients felt that they had no acceptance from others. Some participants even feared persecution due to their illness and lack of understanding (they were considered as 'others' and 'strange').

'Enhancing psychological well-being' highlighted three aspects: the sense of self-esteem and belief in themselves, hope and purpose, and emotional well-being. Therefore, in terms of self-esteem and self-belief, the respondents thought that religion helped them accept themselves and stop criticizing themselves for the illness. They felt less stress about the difficult experiences of health recovery and felt that religion helped them understand that they are also unique and can achieve their full potential. In turn, in terms of 'hope and purpose', it was observed that religion contributed to the development of the respondents, i.e., they began to see themselves in a better light and create goals for the future. In turn, 'emotional well-being' translated into the perception of patients that religion has a soothing effect on them. Even in difficult situations, faith was able to calm them down. Thanks to religion, they were happier, and for some of them, religion had a cleansing effect. Through confession, they were able to vent their feelings and God forgave them in return for the prayers. Moreover, some patients stated that it was religion that saved them from self-harm and even suicidal attempts.

'Making sense of experiences' reflects the patients' feelings during the disease. Thus, they considered the beginning of psychosis and a hospital stay as the time to explore various explanations as to the reasons for their current life situation. They heard different opinions from health professionals and religious authorities. At the end of the day, patients experienced a lack of a clear-cut explanation. In the end, some turned to the Scriptures

to seek religious explanations. However, others relied on medical staff to confirm the explanation of the disease. In the absence of specific answers as to why they fell ill, the recovery times was notably longer. The last conclusion relates to the variable nature of the understanding. For some, religion allowed them to revalue their experiences, while others benefited from the development of medical-based explanations.

Therefore, it seems that patients could benefit from the clinicians' interest in non-standard, in-depth ways of understanding experiences known as delusions or concentration on religious practices, which at first sight appear ridiculous, absurd, and inadequate to reality. Sikora (2019) rightly points out that the inclusion of religious beliefs in an interactive model—and their association with emotions, behaviors, and often strong physiological reactions of the organism—allow the understanding that a whole range of more complex emotions can be experienced in connection with religious or spiritual thinking, but they are still the same common, human emotions. Similarly, 'behaviors related to religion' will include not only externally observable religious practices but also behaviors resulting from moral or even aesthetic decisions. It is therefore not necessary to undermine the patient's convictions, going beyond the religious system to which they admit. However, it is worth making efforts to learn the religious tradition of patients and to be able to speak with them in their language. This will not be possible without at least a basic, unbiased knowledge of at least the main religious doctrines and openness to the diversity of beliefs and experiences in the field of religion/spirituality. Even this early analysis indicates that a psychotherapist determined to include and actively involve the patient's religious beliefs in the treatment process is facing an extremely difficult task both from a substantive and ethical point of view (Sikora 2019). It is therefore noted that the diagnosticians and psychotherapists should broaden their knowledge, self-awareness, own convictions or emotional disposition regarding religious traditions and doctrines, rituals, and experiences valued in the community concerned.

In the case of patients with schizophrenia, religion can become both a protective factor and a risk factor, which is an important aspect when planning the treatment. As already mentioned, for many patients, religion plays a central role in the processes of reconstructing a sense of self and recovery. For psychotic patients, however, religion may become both an element of the problem and part of the recovery. This should be taken into account in the treatment process. Religion may help to reduce pathology, enhance coping, and foster recovery. The treatment should incorporate respect for diversity and restriction of persuasion. Longitudinal research among psychotic patients on the effectiveness of treatment that took into account their religious involvement shows diverse therapeutic effects (Mohr 2006). The use of religion can help or significantly hinder recovery. For persons active in a religious community, religion can also be a highly valuable tool to cope with the disorder (Helman 2018).

A specific pattern of relationship between psychotic disorder and religion can be elicited. Spiritual or religious involvement can lead to violent behavior and refusal of treatment, but also helpful psychiatric care and strategies for coping with the illness (Mohr and Huguelet 2004). Research suggests that reconstruction of a functional sense despite persisting dysfunction plays a central role in the recovery from mental disorders (Davidson and Strauss 1995). Spirituality and religion may play a central role in many patients' lives thanks to religious symbols that integrate *Self* and the sense of being (Corin 1998). Religion provides some patients with identification models which, with the active support of the religious community, can facilitate recovery (Holm and Järvinen 1996). It is difficult to differentiate if a religious experience is genuine to the spiritual person, or if it is a positive symptom of the illness (Koenig 2007). However, this exploration of the relationships between religion and schizophrenia leads from pathology and coping with illness to the necessity of taking into account spirituality when caring for people suffering from schizophrenia. It is entirely possible to combine religion with professional therapeutic measures and medication to meet the desired goal. While undergoing psychiatric treatment, those who were religiously involved and spiritual daily reported fewer symptoms and

a better quality of life. They came to see their religion as a source of hope rather than a tormenting reality (Mohr and Huguelet 2004).

7. Conclusions

In the article, the authors addressed the role and significance of religion/spirituality in the development of mental health, recovery and etiology, pathomechanisms, and psychotherapy of disorders on the example of schizophrenia. Although research examining religion, spirituality, and mental health generally indicate positive associations, there are also potentially negative aspects. The increasing number of theoretical analyses and clinical trials on the pathogenesis of schizophrenia paradoxically contributed to the understanding of the significance of religion in salutogenesis. This resulted in a modification of the perception of religion by professionals, including psychologists or doctors, when assisting schizophrenia patients in their recovery. In addition, the recognition of the religious and spiritual needs of patients is proving to have a significant impact on the effectiveness of cooperation.

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