Religion and spirituality in the context of bipolar disorder:

A literature review

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Religion and spirituality in the context of bipolar disorder

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Abstract

Bipolar disorder (BD) affects approximately half a million Canadians. Religion and spirituality (R/S) may play an important role for individuals with BD by providing a means of coping with, and an explanatory model for, their disorder. We conducted a systematic review of empirical studies that have explored R/S in individuals with BD or samples that explicitly delineate individuals with BD. Only six studies met our inclusion criteria. Findings from these studies suggest that R/S strategies may be important for some people in the management of BD. Religion and spirituality thus become relevant concerns for a therapeutic regime that seeks to develop wellness within a bio-psycho-social model. However, the limited body of research and methodological shortcomings of existing research make it difficult to draw relevant conclusions about how this might be accomplished. The authors propose a need for longitudinal, prospective, mixed methods research in order to inform evidence-based practice.

Key words: bipolar disorder, spirituality, religion, review

Introduction

In recent decades, religion and spirituality (R/S)¹ have figured more prominently in health science literature. A growing body of empirical literature suggests that R/S is a salient concern for some patients' mental health. Positive mental health outcomes such as improved coping (Phillips & Stein, 2007, 2000; Tepper, Rogers, Coleman, & Malony, 2001), decreased substance use (Huguelet, Borrás, Gillieron, Brandt, & Mohr, 2009; Rew & Wong, 2006), and greater subjective states of wellbeing and quality of life (QoL) (Sawatzky, Ratner, & Chiu, 2005) have been shown to be associated with R/S; although this relationship is influenced by the nature of the R/S under consideration (Koenig, 2009) and by the fact that R/S is often measured by indicators that have also been used as indicators of mental health (Koenig, 2009).

Further, the globalization of religion (Thomas, 2005), and popular societal interest in spirituality (Bibby, 2006), requires mental health professionals to acquire knowledge of the divergent health belief systems that arise from R/S. Understanding the belief systems of individuals under care can provide important insights into explanatory models of mental health thereby enabling the clinician to better understand health-seeking behaviour. Unlike a purely biomedical approach, this approach focuses more specifically on individual, cultural and societal resources that can be used to treat the person within their social context. Most studies concerned with the relationship between R/S and mental health have focused on major depressive disorders, anxiety, substance use and psychotic disorders (Koenig, 2009). Few have addressed how R/S plays a role in the mental health of individuals diagnosed with bipolar disorder (BD).

¹ In light of the evolving nature of these terms, and the ways they are used in the various disciplinary literature, we have chosen to use both religion and spirituality (R/S) in an attempt to be inclusive of these understandings.

Bipolar disorder is both complex and heterogeneous, affecting approximately a half a million Canadians (Schaffer, Cairney, Cheung, Veldhuizen, & Levitt, 2006). An individual with BD can experience symptoms of depression, mania, hypomania, or psychosis, combinations of these emotional states, or rapid cycling between them (American Psychiatric Association, 1994). Marked variability occurs between individuals in terms of the type, number and length of episodes experienced over a lifetime, the severity and type of symptoms encountered, and the degree of inter-episode recovery achieved. Until recently, research into BD has been guided by a bio-medical model conception; compared to work in the schizophrenia or unipolar depression fields, relatively little attention has been paid to psychosocial or cultural factors that may play a role in maintaining health or wellness in BD. This is also the case for the study of R/S in relation to BD, although there is a clear and compelling rationale for the importance of exploring understandings and experiences of these constructs with reference to BD.

Understanding more about the relationship between R/S and BD is particularly important in that the symptoms of BD often include R/S delusions. Individuals with BD, particularly during episodes of psychosis, frequently report mystical experiences with religious themes (Menezes & Moreira-Almeida, 2010). These may entail believing that one is God, hears messages from God, or has a divine mission (Raab, 2007). However, it is not always easy to disentangle religious delusions from religious experiences common to those individuals who do not have a diagnosis of mental illness. It may actually be the level of preoccupation, conviction and extent of the thinking rather than the content that marks it as delusional (Pierre, 2001). In particular, it is important to be able to differentiate religious delusions from spiritual emergencies (Johnson & Friedman, 2008). Menezes and Moreira-Almeida (2010) define Spiritual emergence as “critical stages of a deep psychological change that result in uncommon states of consciousness, intense

emotions, visions, unusual thoughts, and several physical manifestations.” (p. 175). Failure to differentiate the two may actually cause misdiagnosis and iatrogenic harm (Menezes & Moreira-Almeida, 2010) which may in turn discourage individuals from seeking treatment from healthcare providers. Further, there are often cultural factors that determine whether a religious experience is labelled as abnormal. For example, the same claim to possession by an evil spirit which might be considered delusional in a North American context might be revered in a Haitian context, particularly within voodoo traditions (Johnson & Friedman, 2008). Koenig’s (2009) review of the literature exploring psychosis and mental illness reported that few studies have examined the relationship between religion and psychosis, despite the frequent co-morbidities. However, he did conclude that overall religion may play a positive role in the lives and treatment of those who experience psychosis. The challenge then becomes how to incorporate religious experiences into the clinical care of individuals with BD.

Given the changing zeitgeist with regards to role of R/S in mental health, we undertook a review of the existing literature addressing R/S in relation to BD. Our aim was to conduct a systematic review of existing empirical studies that have explored R/S in individuals with BD or patient samples that explicitly described the inclusion of individuals with BD.

Methods

This review was conducted by a multidisciplinary team (comprising individuals with nursing and psychology backgrounds and a co-author, VM, who has lived experience of BD) that summarized the empirical research on R/S in individuals diagnosed with bipolar spectrum disorders (specifically, BD type I, type II or cyclothymia). Studies were included if they addressed R/S as a major consideration or finding of the study and contained a clear sample or subsample of individuals with BD. The following computerized databases were searched by two

of the co-authors (NC and BP): Medline (OvidSP), CINHAL (Ebsco), EMBASE (Ovid), PsychINFO (Ebsco), AgeLine, Cochrane Database of Systematic Reviews, Database of Abstract of Reviews of Effects (DARE) and Web of Science. The reference sections of relevant articles were searched for additional studies. Key words included: “spirituality” or “religion” or “religious beliefs” or “logotherapy”. These terms were combined using ‘and’ command with “bipolar disorder” or “manic depression” or “mood disorder” or “mania” or “cyclothymia”. Six studies were identified that met the inclusion criteria (see Table 1).

[insert Table 1 about here]

Findings

Of the six studies identified, only one used a qualitative approach. Michalak, Yatham, Kolesar and Lam (2006) conducted a qualitative study to explore QoL in individuals with BD. In-depth interviews were conducted with 35 individuals with BD, including both type I ($N = 22$) and type II ($N = 10$). R/S figured prominently in the findings. Over one third of the participants discussed the importance of R/S to their lives; although the integration of R/S with BD could be problematic. Disentangling ‘real’ spiritual experiences from hyper-religiosity was not always easy. For example, engaging in religious activities could be beneficial in the day-to-day management of the disorder, but excessive engagement could be indicative of a worsening condition. Participants could not necessarily turn to healthcare providers for help because of the perception that religious thinking would automatically be regarded as a symptom of the disorder, rather than a coping strategy. R/S became a hidden personal resource. The role of the religious community was also complicated as participants had to balance the support they received with a lack of understanding of their symptoms. Although this study provides an in-depth and revealing look at some of the experiences of R/S in the context of BD, the results must be viewed in light

of the small sample size and the qualitative method that does not aim to produce generalizable findings.

Five quantitative studies described some aspect of the relationship between R/S and BD; although only two focused exclusively on individuals with BD. Mitchell and Romans (2003) used a cross-sectional survey to investigate the spiritual beliefs of New Zealand individuals with BD and their relevance for illness management. Eighty-one individuals completed surveys about their types of beliefs (religious, spiritual, philosophic), how those beliefs influenced the management of their illness, and congruency of explanatory models and treatment regimes between themselves, healthcare providers and spiritual leaders. The majority (94%) indicated some form of belief about the world, whether spiritual, religious or philosophic, and 79% held those beliefs strongly (greater than 5/10 on a visual analogue scale [VAS]). The degree to which participants found their R/S beliefs helpful was strongly associated with believing in a higher power and seeking spiritual healing. R/S belief-holders were significantly more likely than philosophical belief-holders to find that their beliefs helped manage their illness. Seeking spiritual healing through meditation, group prayer and physical action were significant in helping to manage illness. Those who practiced their faith non-organizationally were more likely to find that their beliefs helped them. The findings regarding beliefs, illness views and treatment were revealing. Those with weaker strengths of belief scored significantly higher on subjectively reported adherence with medications. Twenty-four percent of participants rated differences in illness paradigms between themselves and their care provider as stronger than 5/10 on a VAS. Nineteen percent claimed to have experienced conflicting advice between their spiritual leader and their healthcare provider. One third of these had been told by their spiritual leader that they no longer required medication because they had been cured spiritually. This study illustrates both

the role that R/S beliefs may play in managing illness and the potential challenges that may arise with treatment regimes if explanatory models of the disorder are substantially different. This study is particularly useful in its exclusive focus on BD and its interesting descriptions of the influence of R/S on treatment regimes. However, the design was cross sectional and correlational and so any type of causal relationships cannot be determined.

A recent cross-sectional, observational study conducted by Cruz, Pincus, Welsh, Greenwald, Lasky and Kilbourne (2010) suggested an association between different forms of religious involvement and clinical status of individuals with BD. Their sample consisted of 335 participants from a Veterans in Care-Mood Disorders Clinic (CIVIC_MD) in a large urban mental health centre. Using bivariate and multivariate statistical methods, their study specifically aimed to explore the relationship between an individual's dimension of religious involvement and different mood states that fall within the BD spectrum. Religious involvement was measured by the Duke Religious Index (DRI) that captured individual private (prayer/meditation), public (church attendance) and subjective (beliefs on life) aspects of religion. Mood state was assessed by the Internal State Scale (ISS), which measures both manic and depressive symptoms and contains four subscales, two of which were utilized to categorize individuals as to depressed, manic/hypomanic, euthymic or mixed mood states.

Findings from the study suggested that church attendance, prayer/meditation and beliefs on life were all significantly associated with euthymic and mixed states when compared with manic or depressive states. However, when functional disability (anxiety and binge drinking) was controlled for, higher rates of prayer/meditation were associated with being in a mixed state and lower rates were associated with euthymia. Unlike findings from Mitchell and Romans study, Cruz et al. (2010) suggested that individuals who are in a mixed state may not be able to

access external resources due to impaired functional ability and greater distress. Cruz et al. (2010) have noted several limitations to their study design. While prayer/ meditation were significantly associated with mixed states of BD, their analysis could not address whether prayer/meditation is a helpful means of coping or a behavioural consequence of underlying psychopathology. It was noted, however, that patients in manic and psychotic states were excluded from the study; their inclusion may have helped to draw associations between religious behaviours, beliefs, mania and psychosis.

Another limitation of the study relates to sample characteristics; the study sample consisted of veterans, and it is possible that the association between prayer/meditation and mixed states of BD may have been confounded by a history of complex trauma. The authors recommended that mental health clinicians acknowledge the R/S component of patients with BD and explore the nature and influence of R/S on treatment and help-seeking behaviours.

The remaining three studies included only subsamples of individuals with a diagnosis of BD, making it more difficult to draw conclusions. Brewerton (1994), using a retrospective chart review, examined religious content, hallucinations and delusions across various psychotic disorders including bipolar mania, schizophrenia with and without focal temporal lobe EEG abnormalities, and psychotic depression. Individuals with bipolar mania (N = 10) showed the highest frequencies of hyper-religiosity within the diagnostic subcategories, but the inferences that can be made on the basis of this small sample size within the context of a retrospective design are limited. Kroll and Sheehan (1989) described the religious beliefs, practices and experiences of 52 psychiatric inpatients, 11 of whom were diagnosed as having a DSM-III-defined manic episode. The majority of these individuals expressed religious beliefs about God (100%), the Devil (64%), an afterlife (73%), and believed the Bible referred to daily events

(82%). However, there was little corresponding involvement in religious practices except for consulting the Bible and praying about decisions (73%). Again, the small size of this study and the limitation of the sample to those experiencing episodes of mania limits generalisability.

Religious coping in BD was the focus of the final study identified. Reger and Rogers (2002) conducted a secondary analysis of a larger study on religious coping in individuals with severe mental illness across a variety of in- and outpatient care settings in the United States (Tepper et al., 2001). Four hundred and fifteen individuals recruited from Los Angeles County mental health facilities completed a religious coping index and a demographic survey that included items related to religious participation. The sample was divided into five diagnostic groups, of which BD was one ($N = 58$). No diagnostic differences were found in types of religious coping. Individuals diagnosed with schizophrenia, schizoaffective disorder or BD reported using religious coping for significantly longer compared with individuals with depressive disorders (mean of 17 versus 11 years). However, length of use of religious coping was correlated with length of illness for the whole sample; but length of illness data was not detailed by diagnostic category, creating a potential confound. There were no significant differences reported in terms of perceived helpfulness of religious coping between those with BD and other types of diagnosis. A limitation of this study was that it measured religious coping as an instrumental construct consisting of religious activities such as prayer, meditation and reading scripture. More nuanced approaches take into account both positive and negative coping strategies and how one chooses to assign responsibility to themselves and God in seeking to control circumstances (Pargament, 2002; Pargament, Magyar-Russell & Murray-Swank, 2005).

Discussion

The most remarkable conclusion to be drawn from this review is the lack of attention given to R/S and BD in the empirical literature in light of the prevalence of BD in Canadian society and the increasing societal interest in R/S. In part, this may be explained by a tendency to see religiosity as a manifestation of the disorder itself, rather than part of the broader psychosocial context that influences the disorder. The dichotomy apparent in this review between studies that focus primarily on hyper-religiosity and studies that focus on R/S as a resource highlight the discrepancy between an orientation that emphasises pathology and another that emphasises building upon psychosocial resources. Only Michalak et al.'s (2006) qualitative approach allowed for a rich description of how R/S as resource and disorder could co-exist. It was revealing that 40% of participants in Mitchell and Roman's (2003) study would have preferred an interview format rather than a questionnaire. Qualitative inquiry is necessary to more fully understand patients' experiences of R/S in the context of BD.

Studies identified in this review support the idea that R/S is an influential factor in the lives of some individuals living with BD. Over one third of individuals in Michalak et al.'s (2006) study mentioned it as a relevant factor in relation to QoL. Religious practices, particularly prayer, played a significant role in managing illness in the studies conducted by Mitchell and Romans (2003) and Kroll and Sheehan (1989). These findings should not be construed to mean that R/S is any more important in individuals with BD than it is in the general population. Reginald Bibby's (2006) surveys of Canadian society suggest that 82% of Canadians believe in God, 72% claim to have spiritual needs, 38% would say that spirituality is very important to them, and 31% state that their interest in spirituality has increased in recent years. Although only about 35% of Canadians are actively involved in religious institutions, 72% engage in private

prayer. Similar proportions of individuals with BD report using prayer as non-pharmacological treatment (Dennehy, Gonzalez, & Suppes, 2004). Statistics indicating the importance of R/S seem to be fairly similar across the general population and BD cohorts. However, what is significant from this review is how challenging it may be for individuals with BD to maintain a supportive R/S perspective amidst the variability of their illness. Participants in Michalak et al.'s (2006) study highlighted the difficulties of maintaining institutional religious connections when others might not understand their symptoms. Kroll and Sheehan's (1989) study highlighted that, despite the importance of R/S beliefs, most had little corresponding formal religious practices. For those with BD who could benefit from the social support provided by institutional religion, there may be significant barriers to participation.

While Cruz et al. (2010) found a significant association between prayer/meditation and mixed state, their study did not address how participants' beliefs affected their adherence to medical treatments or perceptions of care. Even more compelling are the potential barriers between individuals with BD and healthcare providers when R/S beliefs and practices enter into the care-giving encounter. Both Michalak et al.'s (2006) and Mitchell and Roman's (2003) studies highlighted the difficulties patients encounter when their explanatory accounts of illness or treatment regimes come into conflict because of R/S beliefs. The potential importance of R/S in clinical encounters should not be underemphasized. The landscapes of meaning derived from R/S can, for some, affect both coping ability and healthcare decisions. To ignore or refute those landscapes of meaning in clinical encounters may inadvertently promote alienation from treatment regimes (Pargament, 2002). Therapeutic clinical encounters should strive to include matters of R/S in the bio psycho-social approach (Gonsiorek, Scott, Pargament & McMinn, 2009; Maxwell & Michalak, 2010). Borrass and colleagues (2007) reported that over 30% of

individuals with schizophrenia who were non-adherent with their medications reported a conflict between their spiritual beliefs and their attitudes toward pharmacological and therapeutic interventions. However, much more needs to be understood about how R/S can be incorporated into clinical encounters while maintaining appropriate therapeutic boundaries and evidence-based practice, particularly in a diverse society.

Although the literature addressing R/S in BD is at an early stage, substantial work has been done in the area of R/S and unipolar depression. Koenig's (2009) review of the interface between religion, spirituality and mental health reported that over 100 quantitative studies had examined the relationship between religion and unipolar depression prior to the year 2000, and that this body of work is developing apace. Findings from the review suggested that religion may play a beneficial role for individuals experiencing depression. Recent studies have suggested that people with high levels of intrinsic religious motivation, who uphold religious values according to their own inner beliefs, may be less prone to depressive disorders (McCullough & Larson, 1999). On the other hand, there is mixed evidence as to whether extrinsic religiosity (that is, the use of religion for social support) is associated with better outcomes. Cross-sectional and longitudinal studies have linked lower depression with religious social support (Baetz, Larson, Marcoux, Bowen & Griffin, 2002; Mueller, Plevak, & Rummans, 2001); however, Baetz and Toews (2009) suggest that the mediating mechanisms associated with R/S may compound depressive symptoms within the social domain. For example, individuals may experience negative social interactions within their religious affiliations, either because of their depressive symptomatology or because they may avoid or discontinue medical treatment. This observation resonates with some of the findings identified in this review in relation to BD, where individuals who experience symptoms of depression or mania described conflicting social experiences

within the context of their religious community. Less empirical work has been done in the area of R/S and psychoticism (Koenig, 2009), one potential mood state in BD. While it is encouraging to see increasing attention being paid to developing our understandings of R/S in mental health disorders such as unipolar depression and psychotic disorders, one cannot assume that the findings from this body of research will adequately represent the complex experiences of people diagnosed with BD, who may experience symptoms of depression, mania, hypomania, or psychosis, combinations of these emotional states, or indeed rapid cycling between them, and extrapolations between these research fields must be made with caution.

Further, the complexity of the religious experience needs to be accounted for more adequately. It is difficult to make comments about the use of religious measures in such a small body of research. However, conclusions about the role of religion in these studies illustrate some of the challenges of religion as a construct in empirical work. Pargament (2002) has argued that empirical research has tended to treat religion too simplistically as evidenced by generic conclusions about the efficacy of religion. Rather, he has argued that the study of religion should take a more nuanced approach recognizing that some religious perspectives may be more helpful than others, and that religion varies across contexts within which it is enacted (e.g. culture, denomination, level of personal commitment, and life situation). The polemics that characterize religion in society seem to also characterize religion in scientific endeavours. There is an urgent need for a more nuanced understanding of the relationship of R/S to BD.

In addition, careful attention should be made to potential problems with the measurement of religion and well-being. Measures of religion that rely primarily upon psychological well-being or mental health are confounding constructs (Moreira-Almeida & Koenig, 2006). Measure of well-being that fail to take into account the unique factors of religious well-being will not

adequately represent religious perspectives (Pargament, 2002). For example, an individual living with BD may experience religious well-being if they retain feelings of connection to a sacred source and their community of faith. There is a need for measurements of religion that do justice to the potentially unique role it plays in coping and health while allowing for its contributions to both well-being and distress (Pargament et al., 2005). The same careful attention made to the complexity of the experience of BD (e.g. type and mood state) should be applied to the complexity of the experience of R/S.

The review had a number of limitations. Only English language articles were included. This could be a significant limitation in terms of the cultural scale of our findings and the fact that much of this literature, because it is not considered scientifically mainstream, may exist outside of recognized academic databases. Further, from a cross-cultural perspective, experiences that may be spiritually revered in some contexts may be pathologised within mainstream western healthcare. Our findings reflect only one dominant perspective of these complex relationships. The literature that we did find was constrained methodologically by small sample sizes with limited heterogeneity, cross-sectional or retrospective designs, limited measurements and poor descriptions of sample characteristics. Although one might expect this at this early stage of inquiry, the limitations in this body of literature can provide a framework for future work in this area, which would benefit from greater attention to rigour in the measurement of the R/S construct and illness-related characteristics and prospective designs.

Conclusions

The scant existing research identified in this review suggests that R/S factors may be one of a wide range of psychosocial variables that have a role to play in determining outcomes in BD. A theoretical perspective that recognizes that R/S can hold relevance both in terms of

adverse manifestations of the disorder and in terms of potentially protective effects will be important, as will an understanding that R/S as resource and pathology are not mutually exclusive, nor commonly agreed upon across cultures. Carefully designed longitudinal studies utilizing qualitative and quantitative methods are essential. Longitudinal studies are particularly important in light of the spiritual and religious transformations that occur in individuals over time. Qualitative studies are necessary for an in-depth understanding of two complex experiences, R/S and BD. For quantitative studies, solid measurements of R/S are required to capture this complexity. Measurements anchored in the unique contribution of religion (i.e. the sacred) (Pargament et al., 2005) and that are , sensitive to important contextual factor such as culture, denomination and individual expressions, will be required for a comprehensive understanding of the interplay between R/S and BD. Future research should also focus on questions of how R/S affects orientations, motivations, social support and struggles (Hill & Pargament, 2003) for individuals with BD and how living with BD affects relevant R/S outcomes.

The findings contained within this review are at a nascent stage, and so it is difficult to make clinical recommendations beyond that of an urgent need for further study. R/S understandings and experiences are not homogenous in globalized societies, but instead diverse and varied. There is a need to understand the ways that clinicians can ethically and effectively include diverse R/S experiences and beliefs into the therapeutic regime. Clearly, clinicians should not be advocating for R/S as a means to mental health or crossing the boundary between psychological and religious treatment (Gonsiorek et al., 2009). But clinicians do need to understand how to incorporate religious explanatory models into evidence-based treatment

regimes and be sensitive to the ways that individuals use religion as part of their “personal medicine.”

Bipolar disorder is a uniquely complex psychiatric condition due to its inherent heterogeneity and marked variability in course and mood states. As such, it also offers the R/S research community a unique window through which to view the relationship between R/S and mental health more broadly.

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