



Original Paper

Moving Beyond Christianity: Islam, Judaism, Hinduism and Mental Health

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Abstract: *To date the literature on religion and mental health has focused upon Christianity. We cannot assume that these findings can be transposed onto other faith groups. In this paper I focus upon Islam, Judaism and Hinduism and discuss understandings of mental illness and the relationships between central beliefs and mental health. I discuss implications for clinical work and psychotherapy.*

Keywords: *Mental health, Christianity Islam, Judaism and Hinduism*

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INTRODUCTION

By now several thousand studies have been conducted demonstrating positive associations between mental health, spirituality and religion (Koenig, King and Carson 2012). Those who are more religious generally manifest better indices of mental health. The vast majority of studies have been cross-sectional and have focused on religious attendance and beliefs among North American Christians. There has been far less work examining rituals, prayers and other aspects of being religious such as religious experience (Dein and Littlewood 2007; Dein 2010).

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On balance, being religious results in more hope and optimism and life satisfaction (Koenig 2009), less depression and faster remission of depression (Koenig 2007, Smith, McCullough and Poll 2003), lower rates of suicide (Van Praag 2009), reduced prevalence of drug and alcohol abuse (Cook, Goddard and Westall 1997) and reduced delinquency (Johnson, Larson and McCullough 2000). Studies on anxiety demonstrate rather mixed results. Although some studies demonstrate reduced anxiety rates, others find that anxiety levels are heightened in the more religious (Koenig, King and Carson 2012, Shriv- Neiger and Edelstein 2004). Work on schizophrenia is still at an early stage; recent studies in Switzerland suggest that religious individuals with psychotic illnesses deploy prayer and Bible reading to help them cope with their voices, and higher levels of religiosity may increase medication compliance (Mohr et al. 2006, Mohr et al. 2011).

Compared to Christianity, relationships between Islam, Judaism and Hinduism and mental health have received far less attention. We cannot assume that the findings from Christianity can be applied to other faith groups. Furthermore, understanding of the relationships between specific beliefs in each faith tradition and psychopathology is essential for conducting psychotherapy for adherents to these faith traditions. Recently a number of measurement scales have been devised to look at the dimensions of religion in non-Christian groups (eg Abu Raiya 2005 among Muslims, Tarakeshwar, Pargament and Mahoney 2003 among Hindus). Relationships between religion and mental health may differ between Christianity and other faith groups due to different understandings of religion, spirituality, mental health and God in these faith groups. I begin with Islam.

Mental Health in Islam

Islamic perspectives on health and healing are based upon the Qur'an, Hadith and Arabic folklore. Islam maintains that humans are composed of four parts which interact with each other: *Aql* (mind), *Jism* (body), *nafs* (self), and *Ruh* (soul/spirit). A harmonious relationship between these parts is deemed necessary in order to maintain health, both physically and mentally; mental illness results from an imbalance between them. It can result from demonic possession by *jinn*, a result of witchcraft or as a natural manifestation (Ally & Laher, 2008). According to these authors, treatment of mental illness frequently involves *holy men* who conduct an exorcism where the Qur'an is read to the patient (*ruqya*) as well as blown on them and written on paper to be kept with the patient at all times. Daily prayer and remembrance of the Almighty are also considered efficacious treatments. These therapeutic modalities are held to restore the belief of the individual, considered the essential element to healing.

One commonly held explanatory model among Muslims of mental illness involves spirit possession. While Western societies commonly assert that Muslims see mental illnesses as due to demons or evil spirit-related, it was in fact the Europeans in the Medieval Period who viewed mental illness as demon-related. Muslim scholars at that time, including Ibn Sina (known in the West as Avicenna - the founder of Modern Medicine), rejected such concepts, instead viewing mental disorders as conditions that were physiologically based.

In relation to explanatory models there is evidence that psychotic illness may be interpreted in terms of Jinn possession. Lim, Hoek and Blom (2014) note that the attribution of psychiatric symptoms to jinn appears frequently among Islamic patients, and significantly it impacts the diagnosis, treatment, and course of mental disorders, particularly psychotic disorders. It is essential to understand these spiritual explanatory models when working therapeutically with Muslims (Dein 2016).

In terms of religious coping the Qur'an can facilitate coping with adverse life events. Muslims are adjured to submit their will to God alone and to believe and trust that He will take good care of them, irrespective of what occurs. They should admit their limitations and worry only about what's in their knowledge and ability as a human, and leave the rest to God's wisdom. Islam plays an important role in helping Muslims to cope with negative life events, which helps them in both prevention and treatment of depression. Those experiencing negative feelings are encouraged to resist them with positive thoughts and actions if possible, or to seek professional help if the case is clinical, exactly like any other form of illness.

“So, verily, with every difficulty, there is relief: Verily, with every difficulty there is relief.” (Quran, 94: 5-6).

Islam encourages followers to remain hopeful, even if someone has committed the worst sin or faced with most troublesome life event as there is always God's mercy.

“And never give up hope of Allah's soothing Mercy: truly no one despairs of Allah's soothing Mercy, except those who have no faith.” (Quran, 12:87).

Despite the fact that Islam is considered the second largest religion of the world, there is a dearth of empirical studies conducted on the psychology of the Muslim population (Abu-Raiya, Pargament, Stein, & Mahoney, 2007). Regarding Islamic spirituality, Abu-Raiya and Pargament (2010) note that most of the research conducted on Islamic spirituality/religiosity have deployed either a single variable to measure religiousness, or are translations or adaptation of a western tool based on Judeo-Christian spirituality, which may make their use with the Muslim population somewhat ineffective.

While there is relatively little empirical research on Islam and mental health, Koenig and Shohaib (2014) argue that with few exceptions, Islamic beliefs and practices are generally associated with higher life satisfaction, greater wellbeing, less depression, less anxiety and less substance abuse. In relation to help seeking for mental illness, research suggests that many Muslims are hesitant to seek help from the mental health professionals in Western countries due to the differences in their beliefs and lack of understanding of the helping professionals about Islamic values in their treatment modalities (Hedayat-Diba 2000).

Research demonstrates the effectiveness of the integration of spirituality and religiosity into psychotherapy among Muslim patients (Sabry and Vohra 2013). Studies on Muslims utilizing spiritually modified cognitive therapy for anxiety and depression demonstrated faster results as compared with the therapy that is not Islamically modified. In a similar vein, a study conducted on Muslims with bereavement showed significantly better results with cognitive-behavioral therapy that incorporated Islamic beliefs and practices (Azhar and Varma 2000).

JUDAISM

Compared to Christianity which stresses belief, Judaism is orthopraxic- emphasising religious practice rather than belief. One study found that Protestant groups defined religious involvement by internal faith and a personal connection to God, whereas religious beliefs were less essential than biological descent and ritual practice in defining religion for Jewish individuals (Cohen & Hill, 2007). Rosmarin, Piritinsky, Pargament and Krumrei (2009) point out that while considerable evidence ties religious beliefs to mental health among Protestant Christians, previous theory and research has emphasized that practices play a more important role than beliefs for Jews. However beliefs are still important in Judaism and may impact mental health among Jewish populations.

Recent research underscores the importance of specific Jewish beliefs for mental health. Orthodox Judaism values the conviction in the existence of a unified and omniscient God who is attentive to human behavior, and benevolent in nature. The centrality of this belief is illustrated by the daily recitation by Orthodox Jews of Maimonides' (1168/ 1990) Thirteen Principles of Faith, a classic codification of these beliefs, by many adherents.

Two studies were conducted by Rosmarin, Piritinsky, Pargament and Krumrei (2009) to compare the extent to which beliefs pertaining to God's benevolence predicted depression and anxiety for Orthodox Jews, non-Orthodox Jews, and Protestants. The studies indicated that beliefs were salient for Orthodox Jews and Protestants, but less relevant for non-Orthodox Jews. Among Orthodox Jews, religious beliefs in God's benevolence remained a significant predictor of anxiety and depression after controlling for religious practices.

Jewish perspectives can be integrated into psychotherapy. Rosmarin, Pargament, Piritinsky and Mahoney (2010) found initial support for the efficacy of spirituality integrated therapy delivered through the internet for the treatment of subclinical anxiety symptoms among religious Jews. The cognitive program was developed by the authors in conjunction with Jewish community leaders and teachers. Initially, two ultra-Orthodox rabbis were asked to identify Jewish spiritual strategies for coping with stress and anxiety. Two principal categories of strategies were found: cognitive (e.g., reading inspiring stories and excerpts from Jewish religious literature and behavioural (e.g., spiritual exercises to increase

gratitude, and prayer). The therapy aimed to strengthen the perspective that God is completely knowing, powerful, kind, and loving. These authors suggest that it is important to incorporate spiritual content into treatment to help facilitate the delivery of psychotherapy to religious individuals.

HINDUISM

Hindu has a long tradition of adopting a bio-social-spiritual model in relation to both physical and mental health. Mental health can be conceptualised as a wheel comprising a central axis and three spokes. It comprises the centre -Dharma- (righteousness, virtue and religious duty), and the spokes: Kama (biological), Artha (social) and Miksha (spiritual) (Campion & Bhurgra, 1998). Hindus maintain that illness results from the imbalance between these aspects. An individual can become weakened if their actions result in disharmonious relationships with their community, resulting directly from the Hindu belief that all are interconnected. The Bhagavad Gita describes the balanced person as one who has a controlled mind, emotions and senses. Balance may be restored through practices which include puja rituals, like worship and devotional offerings to god, fasting, and meditating to positive and strengthening messages.

Campion and Bhurgra (1998) in their study of religious treatments of mentally ill patients in southern India, point out how religious leaders assert that religious treatment was not necessarily the most effective method for certain illnesses. If the incorrect therapy is deployed, it could complicate the effects of the illness within that person. Some of the treatments observed were residential stays at the temples, daily prayers and meditations at religious shrines dedicated to the healing of specific psychiatric illnesses, drums and music, and in some severe cases, the patient was chained to the walls in order to increase their focus on recovery. In a similar way Raguram et al (2002) note that traditional community resources, including temple healing practices, are widely used to manage mental illnesses in India. Their study indicated that a brief stay at one healing temple in South India improved objective measures of clinical psychopathology

From a Hindu perspective emphasising interrelatedness, the family is seen as a primary source of strength and support for the person with mental illness (Campion & Bhurgra, 1998). While for men, mental illness is viewed as sorrowful, for women on the other hand it is perceived as shameful or negative omen for the whole family unit deriving from the fact that women mirror the integrity of the family (Navsaria & Peterson, 2007). These beliefs impact the rate in which women are diagnosed as mentally ill, as well as the prevalence of treatment sought.

There has been little work specifically examining mental illnesses among Hindu populations. Behere, Das, Yadav, Behere (2013) argue that guilt feelings are commonly expressed in Indian depressed patients. Mental illness among Hindus may be accounted for in terms of reincarnation. If asked whether his present symptoms are due to some past misdeeds a Hindu is quick to admit the relationship with some unknown sin in past life. One study (Kamble et al 2013) among Indian university students found that the Attitude towards Hinduism Scale correlated positively with the Intrinsic and Extrinsic Personal Religious Orientations, exhibited an inverse relationship with depression, and predicted greater self-esteem and religious collective self-esteem.

RELIGIOUS COPING: SIMILARITIES AND DIFFERENCES ACROSS FAITH GROUPS

There is recent evidence that individuals in each of the major world religions deploy religious resources to cope with life events. While Hindus may emphasise karma, yoga and detachment (Tarakeshwar, Pargemon and Mahoney 2003), Muslims may emphasise religious behaviours such as giving alms in the name of Allah and Jews may rely on community involvement (Rosmarin, Pirutinsky, Pargemon and Krumrei 2009). This is important for psychotherapists working across faith groups to understand.

While there are commonalities in religious coping amongst different faith groups they are also differences. However, the functions of religious coping are generally similar across the three faith groups ie gaining meaning and control, feeling closer to god, comfort and life transformation. Studies

on Muslims (Kahn and Watson 2006) and in Jews (Rosmarin, Pargament et al 2009) found that both groups used positive and negative religious coping. A study of Hindus found the use of negative coping alongside two other forms of positive coping, god focussed and spirituality focussed (Tarakeshwar, Pargament and Mahoney 2003)

In a similar way to Christian samples, for Muslims, Jews and Hindus, more use of positive religion as coping related to better outcomes, whilst negative coping strategies worsened mental health. Greater Islamic positive religious coping was found to relate to less anger while greater Islamic struggle and interpreting stressors as a punishment were associated with greater anger (Aten, O'Grady and Worthington 2014). The different faith groups used different forms of religious coping. Specifically some forms of religious coping are found in Christian samples were not found among other religious groups. For instance, Hindus did not endorse religious forgiving, dissatisfaction with members of religious community and attributing stressful life events to the devil. Thus there may be unique forms of coping.

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