Medium-term religious support program applied to suicidal psychiatric patients

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ABSTRACT

Psychiatric literature generally recognizes the importance of religion and spirituality in the care of religious psychiatric patients. In this work we aimed to investigate the influence of a supportive religious program on religious patients with suicidal ideation. The results confirmed the theoretical predictions of the psychiatric literature regarding the broad positive value of a complementary religious support applied to religious psychiatric patients. A potential negative effect of the most influential Christian Orthodox religious practices used in the therapy of suicidal patients was also noted. These findings may have significant implications for medium and long-term psychiatric interventions in faith-based settings.

KEYWORDS:

Suicide, religious support, depression, spiritual/religious care practice.

INTRODUCTION

The psychiatric literature recognizes largely the importance of religion and spirituality in the care of religious psychiatric patients, recommending collaborative professional spiritual/religious approaches to support them. Moreover, a majority of clinicians acknowledged their responsibility to address the religious/spiritual needs of patients. D'Souza et al. emphasized the need for

psychiatrists to take into account the spiritual and religious dimension of their patients since it leads to the strengthening of the patient-physician relationship and the increase of the therapeutic impact of interventions.(1) Shin et al. showed that physicians of higher religiosity/spirituality were more willing to believe that medically unexplained symptoms of their patients, accounting for 20–30% of primary care consultations, result from a

spiritual issue, underlining the importance of paying attention to the patients' spiritual life.(2) Furthermore, in another study, the majority of German psychiatric staff members expressed their willingness to deal with patients' religiosity/spirituality in therapeutic settings, while clinical chaplains, even if they agreed to the psychiatrists' opening, offered however a different general perception, a result that recommended an increase in collaboration between psychiatrists and clinical chaplains by changing their views on religious/spiritual issues for clinical practice.(3) Also, Judge showed that nurse practitioners should take into account the patients' spirituality needs, especially for chronic cases.(4) Such studies prove that religion and/or spirituality - as important components of people's lives(5) - are largely considered by the psychiatrists to be important in therapy, at least at a functional level.(6) For this reason, the World Psychiatric Association recommended a more direct and close partnership between psychiatry and religion/spirituality at institutional level.(7) Moreover, because religion can help religious psychiatric patients to cope with the stressful circumstances of an illness, psychiatrists are advised to consider the spiritual history of their patients, to support healthy religious beliefs, to pray with patients (if appropriate), and to consult or do joint therapy with the trained clergy.(8) Nevertheless, it is warned that even if praying with religious patients could induce positive effects and increase therapeutic success, the practice may still have some risky features and should only occur if the psychiatrist would demonstrate a good understanding of patients' religious beliefs and if they have good knowledge of and experience with religion.(9)

A series of reports emphasized the key role of the religious factors in reducing the incident depression and suicide rates. An extended study performed on about 50,000 nurses in U.S. found an inverse relationship of the risk of incident depression with the attendance of religious service.(9) Likewise, religious social support was positively associated with the decrease of depressive symptoms, while its

lack predicted an increase of the depressive symptoms and emotional disturbances.(10) Other results have suggested that religious support may not be automatically the result of simple religious attendance, but can however afford exclusive benefits to religious persons, distinctly from social support.(11) In addition, Robinson et al. showed that relationship between religious attendance and mental health differs when evaluated across ethnic groups, infrequent religious attendance being associated with anxiety and suicidal ideation in Whites and Hispanics.(12) Moreover, Koenig et al. found that while baseline religiosity does not moderate the optimism of the persons with major depressive disorder and chronic medical illness, religiosity predicts however increases in optimism over time.(13)

Religion can as well protect against suicide attempts, regardless of social functioning, psychopathology and substance use.(5,14) Religion acts as a protective factor both at the individual and societal levels.(15) For example, the frequent attendance of religious services significantly reduces the suicide risk(16) while weekly attendance may lead to a 42 % reduction in suicide ideation.(17) In another study performed on about 90,000 women in the United States, the suicide rate for attending at least one religious service once a week was about 5 times lower than when never attending.(18) Hence, it seems that even if simple religious affiliation might not automatically protect against suicidal ideation, it does reduce suicide attempts.(19) Similarly, people who were not involved in religious activities had four times higher suicide rates than those with high participation.(20) As a result, religious support is positively associated with recovery from severe mental illness(21) while, more specifically, religious attendance is considered an important independent protection factor against suicide attempts and depression.(22) The reported findings have significant implications for psychiatric interventions in faith-based settings and have emphasized the importance of considering religious practices as influential protective factors against suicide, depression, and psychiatric illness, in

general.(10,23) Hence, given the reported positive impact of religious practices on religious patients, psychiatrists were advised to be willing to work with members of faith communities, chaplains and pastoral workers, and to encourage all fellow psychiatrists to do the same, as religion and spirituality should be seen as essential components of psychiatric training and professional development.(24) In addition, clinicians who are familiar with the faith traditions regarding suicide are better prepared to address crisis situations by religious means as well, and are better prepared for consultation with religious professionals, when considered.(5)

However, despite consistent findings and recommendations on the benefits of religious support for religious suicide patients, the specific content of such a religious supportive program is neither detailed nor applied effectively. Therefore, in this paper, we have designed a consistent and highly flexible religious supportive program containing a series of influential religious activities which were applied to a number of patients with suicidal ideation. The obtained data were analyzed using a dedicated psychological/psychiatric evaluation scale and a religious assessment questionnaire.

METHODS

Study population and data collection. For this study, sixty-seven religious Caucasian patients with suicidal ideation were randomly

divided into two groups (34 and 33 patients, each), the first group receiving continuous religious support for about 6 months between 2018 and the beginning of 2020. A religiously-supported patient withdrew in the middle of the study. The patients were diagnosed with schizophrenia, depression, bipolar disorder, organic personality disorder, anxiety disorder, alcohol withdrawal syndrome. Patients with dementia and oligophrenia were excluded.

The religiously-supported patients (RSP) benefited from religious support both during hospitalization and after discharging. Patients' religious level was evaluated using a religious questionnaire (Table 1), partially inspired from Curlin et. al.(25), while the efficiency of the religious program was assessed through a 21-item Hamilton Depression Rating Scale (HAM-D) that estimates depressed mood, guilt feeling, suicidal ideation, and somatic, vegetative and cognitive symptoms of depression.(26) A high score is an indication of increased mental (and somatic) degradation. Ratings were performed at baseline and at the end of the study. Some of the final interviews were conducted by phone. Participation in this study was done exclusively on a voluntary basis and no reward or favor was offered to patients. Patients were allowed to completely stop the religious support at any time.

Table 1. Religious questionnaire applied for both admission in the study and general evaluation of the religious level

Do you consider yourself a practicing believer?	a). Yes. b). Not. c). Only in part
How often do you attend religious services?	a). Twice a month or more. b). Once a month or less. c). Rarely. d). Never.
What are your religious beliefs?	a). I believe in God; b). I only believe in the afterlife, but I don't believe in God. c). I believe in God and in the afterlife. d). I have no religious beliefs.

How religious do you consider yourself to be?	a). Very religious. b). My religiosity is average. c). My religiosity is low. d). I'm not religious at all
If you encounter difficult situations in life:	a). I ask God for help; b). I do not ask for God's help; c). I only ask for God's help if there is no other way to solve problems d). I believe that I can solve my problems only on my own.
In case of more difficult medical problems, would you agree to have a priest to help you along with the doctors?	a). No, never. b). Yes, to encourage me. c). Yes, because I believe that through prayer, confession and other works of the Church I can be healed or I can more easily overcome my suffering. d). I don't know what to do.
Assuming you know that one doctor believes in God and another does not believe in God, who would you choose to take care of you?	a). The one who believes in God. b). The one who does not believe in God. c). I don't know, my choice would depend on other factors.
If you ever tried to leave this world, what were your thoughts in those moments?	a). I had no regrets. b). I was sorry for what I was doing. c). I was afraid of God's judgment. e). I don't know what I was thinking at the time.
Did you want to be saved when you decided to leave this world?	a). No, I wanted to die. b). Yes, I wish I were saved, no matter by whom. c). I prayed to the Lord to be saved. d). I didn't care if I lived or died.
Who do you think could help you stop making such attempts?	a). Family, friends. b). The Church (God). c). The society. d). No one.
After going through this difficult situation, did you learn anything?	a). Nothing, everything is the same as before. b). Yes, I would never try to repeat such a gesture. c). Yes, I pray more and go to church. d). Yes. I think only God saved me.
Do you think that these dark thoughts occur because of a sin of yours or of some ancestors in your family?	a). I think so. b). No. c). I do not know. d). Yes, and I believe that God can solve all these problems.

Ethical approval. The patients were informed about the subject of the study and offered their informed consent. The institutional ethics committee approved the study.

Descriptive statistic. To examine the differences between the two groups, the Pearson Chi square test and *t*-student test

were used. Reported *p* values for *t*-student test were two-tailed. Means and standard deviations were calculated for quantitative variables. The confidence intervals, CI, for proportions were calculated through Microsoft Excel 2007. Significance was set at standard 0.05.

RESULTS AND DISCUSSIONS

Characteristics of the patients are shown in Table 2. The two groups were almost identically structured, with an over unity women-to-men ratio. There was no significant difference with respect to the mean age. The religiously-supported group included more patients living in rural areas, but the difference is statistically non-significant

($p=0.459$, $CI=0.41-0.65$). There were more patients married or living in cohabitation in both groups, but the statistical difference was also non-significant. The patients of both groups, with a mean age near fifty, declared a mean monthly income of about 160 euro. For both groups, the education was primarily secondary, with no statistical significant difference.

Table 2. Characteristics of the psychiatric patients

<i>Defining characteristics</i>	RSP		Control patients		Statistic significance p^*	Confidence interval (CI) 95 %
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>		
Sex						
Women	20	60	18	54.5	0.618	0.45-0.68
Men	13	40	15	45.5		
Place of residence						
Urban	14	42	17	51.5	0.459	0.35-0.59
Rural	19	58	16	48.5		
Marital status						
Married or living in cohabitation	21	64	25	76	0.284	0.58-0.79
Single	12	36	8	24		
Age (M±SD)	52.9 ± 10.2		52.2 ± 10.1			
Women	52.1 ± 10.4		49.1 ± 12.5		0.743	
Men	54.3 ± 10.1		56 ± 3.7			
Declared income (euro/month)	160 (±70.8) (declared by 21 persons)		159 (±92.3) (declared by 17 persons)			
Education						
Higher	2		3		0.694	0.03-0.17
Secondary	29		30			

* by Chi square test for 5% level of significance

From Table 2, the most notable characteristics of patients are related to their income and level of education. The extremely declared low earnings could represent their pension which, in a favorable scenario, might be part of a larger family budget, given that 70% of the patients were not living alone. However, such a personal low income might impact highly negatively on the social living standards, and even affect the physical existence of the patients. Hence, poverty itself can be one of the main causes of their suicide ideation as a way to get rid of mental pain and, perhaps, to save dignity. Undoubtedly, by lacking the basic financial resources to live

decently and, further, to treat their illness, they have a highly increased stress level. In such cases, they may find a viable refuge in God.

The results showed a statistical significant difference between HAMD scores (Table 3) for both groups ($p < 0.05$ for RSP, and $p = 0.0031$ for control group). However, while for RSP there is a positive difference (16 %) between the mean scores obtained at the beginning and the end of the study, a negative difference (-6.2 %) was found for the control group. This divergence highlights a mental state destabilization of control outpatients in the medium term compared to those who

received religious support. This result suggests that even if the mental state of the control patients is stabilized at discharge, it slightly degrades several months after. Overall, analyzing the percentages, there is a significant difference between the variations

of HMAD means for the two groups, indicating a clear positive role of religious support applied to RSP in the medium term.

Table 3. Statistical evaluation of the scores obtained by RSP using the HAMD scale and a religious questionnaire

Statistical parameters	HAMD		Religious level	
	RSP	Control group	RSP	Control group
p (two-tail)	<< 0.05	0.0031	<< 0.05	0.12
Pearson Correlation	0.65	0.73	0.85	0.90
Difference between means obtained by using <i>t</i> -student test at baseline and at the end of the study (%)	16	-6.2	-11.2	1.2

The religious level improved significantly only for RSP ($p < 0.05$), with a negative difference (-11.2 %) between the mean scores obtained at the beginning and the end of the study. In other words, for this group, the religious score was higher at the end of the study. On the contrary, there is no statistically significant difference between the religious scores obtained by control patients ($p < 0.12$) even if a slight decrease of religiosity (1.2 %) was noted. The results are highly correlated (Pearson correlation >50 %) for both groups and for both types of evaluations.

The religious supportive program (Table 4) was split into two main sections: (a) personal program based on personal prayer, religious reading, attendance of religious services,

including those dedicated to the healing of the sick, consultation of specific religious materials in audio/video format, religious pilgrimages and (b) program conducted jointly with the therapist with theological training and the spiritual priest, respectively, which included common-offered prayers, discussions, confession, Holy Communion, and specific religious services in the patients' home. Both the personal and the common supportive program were adjusted according to the degree of religiosity of the patients and their current psycho-mental state. The supportive program included different series of activities agreed separately with each patient.

Table 4. Detailed, flexible religious supportive program of the RSP

a. Personal program		
Activities at the patients' choice	Recommended frequency	Recommended allotted time
Prayers specific to the Christian-Orthodox ritual: morning and evening prayers	2 times a day	15 (+15) min
Prayers addressed to the Lord Jesus Christ, the Mother of God or a patient's favorite saint (akathist)	once a day	15-30 min
Reading some chapters from the Bible (Gospel) regarding the healing of the sick	once a day	5 min
Reading specific Psalms (from Old Testament) recommended by the Church for finding inner peace and strong support in God	once a day	5-15 min
Reading religious books which describe various good	once a day	10 min – 1h

stories, parables and miracles either from the lives of the saints or occurred today

Participation in the Holy Anointing - a specific religious ritual dedicated to the healing of diseases	once a week	1-2 h
Participation in the Holy Mass	once a week	1-2 h
Listening to religious songs that convey hopeful messages	1-2 times a day	10-20 min
Listening to some spiritual advice and parables of contemporary spiritual Fathers	1-2 times a week	15 min
Watching/listening to religious shows on a religious (radio) television, including online attendance of religious services	once a day	30 – 60 min
Practicing the so-called "prayer of the mind"*	whenever the patient feels the need	the
Pilgrimages to monasteries	twice every 6 months	1-4 days

b. Joint program

Made jointly with the therapist

Prayers offered by the therapist for the patient **	once a day	5 min
Prayers offered by the patient to other patients experiencing a similar difficult life situation***	once a day	5 min
Supportive religious discussions with hospitalized patients	once a day	15-30 min
Maintaining a telephone connection between therapist and patient for supportive religious discussions	once a week	30 min

Made jointly with the spiritual priest

Discussions with the spiritual priest, including through confession	twice a month	
Prayers offered by the clergyman for the patient	-	-
Communion with the body and blood of the Lord, at the recommendation of the priest (Holy Communion)	once a week	-
Specific church services performed by the clergyman or other minister priest at the patient's home	once every 6 months	30 min

* The consecrated formula of the "prayer of the mind" in the Christian-Orthodox ritual is as follows: "Lord Jesus Christ, Son of God, have mercy on me, a sinner." However, patients were able to use modified variants; instead of "have mercy on me," and "sinner" they could use any other expressions they felt were more appropriate for them, e.g., "help me", "give me peace", "protect me", "the suffering," "the helpless" or "the grieving". Patients could repeat the prayer for a period of time of their choice depending on their inner mood. The form of addressing the prayer was at the patient's choice.

** Patients were told that the therapist would pray for them at a certain time in the evening, possibly simultaneously with them.

*** This is a method described in the spiritual-religious literature. Praying out of compassion for another, the person in need prays or learns to pray in fact for himself.

The religious program sought, first of all, to induce a positive and balanced change of the mental state of religious patients by increasing the level of trust, hope,

reconciliation with himself, acceptance of suffering, and by exercising the associated religious practices with increased faith in God, but letting God decide what is best for him. Secondly, the program sought to increase

the level of religious and social interaction within their religious community, through pilgrimages and attendance to religious services of the Church, including healing ones, with direct influence on the mental comfort of the patients. This two-pronged approach could provide the patient with the means for mental rebalancing by deepening the knowledge and experiences of a religious nature regarding the significance and transfiguring value of the suffering, the obligation to fight suicidal thoughts as a moral duty to God, the belief that the endured suffering will be rewarded in the eternal life, and the fact that Christians, be they sick, must be joyful, confident, active, seeing in every event of their life a pedagogy of God for them.

Much of the above religious teachings and recommendations are well known to religious patients. Therefore, they were only recalled, supplemented, consolidated and suggested to be implemented in a more systematic and consistent way through a higher community religious integration that would provide patients with moral, psycho-emotional, possibly material support for difficult cases, a support offered under the spectrum of Church teachings in a sacramental setting.

Taken hierarchically, the personal prayer, as a means of direct relationship with God, was considered a main instrument of the supportive program, given the relative ease of practicing it and the ability to generate positive emotions and living relationships with God or Saints. Patients were asked to follow as much as possible the prayer program which they chose, but they were suggested to pray freely, simply, without any restrictions, without formalities, to speak with God as they speak with the best friend or parent, generating positive emotions in any discussion they have with the Divine. Moreover, if during a usual, traditional prayer, which they read or say according to the chosen program, they will be feeling the need to deprive themselves of the written words in order to express themselves freely to God, in their own words, being animated in those moments of positive emotions, then they were

advised to stop reading the prayer and to engage simply and calmly in a balanced living prayer of request and thanksgiving addressed directly to God. Most patients told they preferred this approach, confessing that the free and simple prayer, addressed with hope and emotion to God, made them feel liberated, relieved, comforted in their hearts, and confident that God would support and will help them to accept and overcome the difficulties that have arisen in their lives, also forgiving those they consider guilty to a certain extent for their troubles.

A key role in improving the mental state of religious patients with suicidal ideation may be the practice of a very short prayer as often as possible (in our case, "the prayer of the mind") in a repetitive manner to keep the mind constantly filled with protective, positive, optimistic impressions. Fighting in such a way against the mental state induced by suicidal thoughts, the mind might be trained to quickly switch from a suicidal state to a stable state (of prayer). Over time, through experience, the method can begin to operate spontaneously as a reaction to any suicidal thought or even as a reaction to other different negative mental states, other than suicidal ones. However, most patients reported that they were unable to practice this prayer constantly and consistently due to the fact that they only could focus on the words of the prayer and its message for a very short time. Even though they felt at ease, other supportive activities seemed easier to put into practice. Probably this type of supportive religious activity would find its utility only in the long-term, backed by a more reliable psychological motivation and only with well-stabilized patients under uninterrupted psychiatric supervision and psychiatric medication intake.

The religious books, afforded to patients from the library of the clinic throughout the study, included various stories with happy ending, parables and wonders, all rendered in simple, accessible language, with the potential to induce a positive emotional effect on their mental state. Religious reading had the largest share during hospitalization, with patients

testifying however that, after discharge, they have unfortunately allocated less time to religious readings due to lack of time and socio-familial problems to which they were exposed. In the case of most patients readmitted in hospital during the study, there was a strong desire to continue the same type of simple religious readings, with happy ending events, in which God or various saints miraculously intervened in solving family, health or social problems of people who believed in God and asked for His help in great faith.

Even though this type of religious support is built on an extreme simplicity in approach and content, the message that was conveyed to patients and the associated effects were likely to move positively, to encourage, to increase confidence, hope and even resignation, leaving in God's care all the insurmountable problems that appeared or will appear in their lives seemingly without a logic of causality. In fact, it is in the human nature to overcome the hard times of life by accessing simple things, easily disconnecting activities and uncomplicated readings with positive and motivating emotional messages that may quickly rebalance mentally even the healthy and highly educated people.

During the study, it was observed that under the pressure of their major health problems, patients paid no attention to the theoretical, theological, or philosophical aspects that the religious support program might involve, being more open to the faith-related discussions based on practical examples, suggestions, and proposals for the purpose of immediate help. This could also be related to their education, mostly secondary, which allowed them to receive faith more naturally, without any further inquiry, conditionality and reluctance. Therefore, many religious people who have not had the opportunity to pursue certain university education might probably have the advantage of being protected from academic dilemmas and theoretical complex analyzes, while maintaining their authentic, unquestionable faith. And whether or not the belief in the healing power of the prayer and relationship with God might induce a placebo

effect is a secondary topic that concerns specialists more than patients.

As regarding the reading of some recommended chapters in the Bible, some patients needed guidance, the biblical message needing some simplification and clarification to be understood undistorted. During hospitalization, religious patients who wished to be told of illustrative stories and events described in the Bible related to their suffering, the example of Job, an Old Testament character famous for his suffering, was considered the most appropriate. From the New Testament, religious patients were told about Jesus Christ's unconditional love for the sick, briefly describing some of the miraculous healings of the sick people obtained through faith.

Attendance of religious services and pilgrimages did not suffer interference from the therapist, being considered particular acts related to the privacy of patients. In fact, the patients' particular religious reflections and feelings were not an object of investigation in this study, the focus being only on the final effect of supportive activities on the psychomental state of patients.

As regarding the relationship between therapist and patients, an important aspect that strengthened it was the friendly proposal that the therapist pray for them. Patients accepted and confessed they would feel better knowing that someone was thinking of their own good, praying for them. Hence, prayer, while maintaining its intrinsic religious value, was also a mediator and catalyst for building a trusting relationship between therapist and suicidal patients by conveying a message of affection to them. In addition, patients agreed to pray unconditionally for other patients, known or unknown, for their well-being and health.

Discussions with patients were generally conducted individually, the allotted time differing from case to case. To normalize the psycho-affective state, the therapist used examples from the religious field in which through prayer, patience, resignation,

forgiveness, mercy, love and trust in God, a suffering person can overcome difficult situations, as was the paradigmatic case of Job. In addition, patients with increased religiosity were told about the cathartic or even missionary valences of suffering, as was the case with St. Paul.

As previously pointed out, due to the general and religious education of the patients, it was considered that a religious support plan built on basic and easy-to-understand theological knowledge would be better suited to the purpose of the study. However, we have to add that a psycho-social interference of religious support simply could not be banned due to the specificity of the support actions. Thus, since religion teaches about love and good deeds that should be offered unconditionally to fellow sufferers, 2-3 psychiatric patients in each group were helped, at their request, to solve some of their problems, by facilitating their access to medical services, other than psychiatric, clarification of medical documents required by medical commissions, listening to their acute problems when they called urgently during an emotional crisis asking for psycho-emotional support, encouraging them to socialize more within their close community, not necessarily a religious one, or referring them to some NGOs that might afford immediate help. Therefore, a pure religious support is difficult to provide and manage because at least a minimal psychosocial influence will always have to be associated to implement it successfully.

In order to increase the success rate, the program needs to be attractive, balanced, very flexible, both in content and development, without interfering with the strong beliefs of patients, even if such beliefs might be theologically wrong. Any kind of obligation or coercion imposed on patients in their state of advanced psycho-emotional fragility would nullify the positive effect of religious support. Likewise, the discussions and guidance must be conducted with great pedagogical tact by the therapist who, by definition, starts from the premise that patients who have declared themselves religious tell the truth and act with

sincerity. Even so, they need to be careful and aware of the specific type of patients they support and that things can evolve in a completely unexpected way. For instance, there may be cases in which psychiatric patients might enter the program by fabricating the answers to the religious questionnaire, while actually not sharing the traditional religious values expressed by the main teaching body of the state-recognized religions. This is however a tolerable action simply because suicide patients may consider such a program a good possibility or opportunity to be helped. Hence, a false failure may be part of the end result.

In the end, it is worth noting the particular case in which one of the declared highly religious patients, belonging to the RSP, withdrew from the study after rejecting God and accepted the "demon". As a child born out a rape, divorced, recovered from cancer, and with multiple suicide attempts, she manifested intense hatred against her mother, while being simultaneously subjected to similar hatred by her own fully-aged daughter. Submitted continuously to an intense psychic pressure, she declared she had a high expectation to solve her problems, but since God didn't respond to her prayers, psychiatry couldn't solve the problem, family and society couldn't come with a viable solution, she chose as an alternative the demonic way. Therefore, a double-edged potential of religion to improve the recovery of psychiatric patients from a mental illness or to accentuate its symptoms²⁷ is confirmed as well by this case. Therefore, religious support must be conducted with high diligence, taking into account the fragile mental condition of patients, even after their discharging, and the possibility that some may no longer follow the prescribed psychiatric drug therapy. Also, religious patients who ask for such support should not be given high expectations for the immediate resolution of their problems, but rather be reminded that the chosen religious supportive program could only help them in the long run along with psychiatric treatment, the latter remaining essential.

LIMITATIONS OF THE STUDY

Since the religious supportive program was very permissive, the patients were free to choose and change, during the study, the activities they considered most appropriate for them. The side effect was that the study suffered from the lack of homogeneity of the applied supportive activities. Therefore, it was not possible to perform a quantitative

assessment of the weight and influence of some supportive activities to the detriment of others, due to the unequal time allocated by different patients for the same supportive activity, and the subjectivity introduced by patients in the implementation of a chosen activity. Also, larger groups of religious psychiatric patients would be needed to increase the accuracy of the results.

CONCLUSIONS

In this work, a detailed supportive religious plan comprising influential religious activities was conceived and applied for approximately six months to a number of Orthodox Christian patients with suicidal ideation. The results showed a statistically significant improvement of the patients' mental state and a slight, but still statistically significant, mental degradation of the control group. The level of religiosity has also improved significantly for the religiously supported patients. By practicing personal or commonly-offered prayer, religious readings, attendance of religious services, consultation of specific religious material, religious pilgrimages, religious discussions, confession to the priest, Holy Communion, or specific religious services performed in the patients' home, all based on the patients' faith in God, the mental state of religious psychiatric patients positively changed in the medium term.

During the study, a declared highly religious patient lost her faith in God and declared she accepted the "demonic" way. Therefore, the predicted risk that religious practices may also accentuate the symptoms of a mental illness is confirmed as well by this particular case. For this reason, religious support should be conducted with caution, taking into account the possibility that some patients may place very high hopes in such a supportive program and even stop following the prescribed psychiatric drug therapy during the program.

Overall, the obtained data confirmed practically the theoretical predictions and expectations of the psychiatric literature regarding the broad positive value of a complementary religious support applied to religious psychiatric patients. These findings may have significant implications for long-term psychiatric interventions in faith-based settings, emphasizing the protective role of influential religious practices against mental illness, in general, and suicide, in particular.

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REFERENCES

1. <https://www.who.int/news-room/fact-sheets/detail/suicide>
2. D'Souza R, George K. Spirituality, religion and psychiatry: its application to clinical practice. *Australas Psychiatry*. 2006;14(4):408-412.
3. Shin JH, Yoon DJ, Rasinski KA, Koenig HG, Meador KG, Curlin FA. A spiritual problem? Primary care physicians' and psychiatrists' interpretations of medically unexplained symptoms. *J Gen Intern Med* 2013;28(3):392-8.
4. Lee E, Zahn A, Baumann K. How do psychiatric staffs approach religiosity/spirituality in clinical practice? Differing perceptions among psychiatric staff members and clinical chaplains. *Religions* 2015;6(3):930-47.
5. Judge D. Holistic Care: Are You Recognizing a Need for Spiritual Care? *JNP - Journal for Nurse Practitioners*, 2016;12(10): e439-e440, DOI: <https://doi.org/10.1016/j.nurpra.2016.06.018>.
6. Norko MA, Freeman D, Phillips J, Hunter W, Lewis R, Viswanathan R. Can Religion Protect Against Suicide? *J Nerv Ment Dis* 2017;205(1):9-14.
7. Curlin FA, Lawrence RE, Odell S, Chin MH, Lantos JD, Koenig HG, Meador KG. Religion, spirituality, and medicine: psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *Am J Psychiatry* 2007b;164:1825-31.
8. World Psychiatric Association. WPA position statement on spirituality and religion in psychiatry. *World Psychiatry*. 2016;15:87-8. doi:10.1002/wps.20304.

9. Koenig HG. Religion and mental health: what should psychiatrists do? *Psychiatr Bull* 2008;32:201-203.
10. Li S, Okereke OI, Chang S-C, Kawachi I, VanderWeele TJ. Religious Service Attendance and Lower Depression among Women - a Prospective Cohort Study. *Ann Behav Med* 2016;50(6):876-84.
11. Holt CL, Roth DL, Huang J, Clark EM. Role of religious social support in longitudinal relationships between religiosity and health-related outcomes in African Americans. *J Behav Med* 2018;41(1):62-73. doi:10.1007/s10865-017-9877-4.
12. Fiala WE, Bjorck JP, Gorsuch R. The Religious Support Scale: Construction, Validation, and Cross-Validation, *Am. J. Community Psychol*, 2002;30(6):761-786.
13. Robinson JA., Bolton JM., Rasic D, et al. (2021) Exploring the relationship between religious service attendance, mental disorders, and suicidality among different ethnic groups: results from a nationally representative survey, *Depression and Anxiety* 2021;29(11):983-990.
14. Koenig HG, Pearce MJ, Nelson B, Daher N, Effects of religious versus standard cognitive-behavioral therapy on optimism in persons with major depression and chronic medical illness, 2015, 32(11), 835-842.
15. Burshtein S, Dohrenwend BP, Levav I, Werbeloff N, Davidson M, Weiser M. Religiosity as a protective factor against suicidal behavior. *Acta Psychiatr Scand* 2016;133:481-8.
16. Vijaykumar L, Suicide and its prevention: The urgent need in India, *Indian J Psychiatry*. 2007 Apr-Jun; 49(2): 81-84. doi: 10.4103/0019-5545.33252
17. Kleiman EM, Liu RT. Prospective prediction of suicide in a nationally representative sample: religious service attendance as a protective factor. *Br J Psychiatry* 2014;204:262-6.
18. Nkansah-Amankra S, Diedhiou A, Agbanu SK, Agbanu HL, Opoku-Adomako NS, Twumasi-Ankrah P. A longitudinal evaluation of religiosity and psychosocial determinants of suicidal behaviors among a population-based sample in the United States. *J Affect Disord* 2012;139:40-51.
19. VanderWeele TJ, Li S, Tsai AC, Kawachi I. Association Between Religious Service Attendance and Lower Suicide Rates Among US Women. *JAMA Psychiatry* 2016;73 (8):845-51. doi:10.1001/jamapsychiatry.2016.1243.
20. Lawrence RE, Oquendo MA, Stanley B. Religion and Suicide Risk: A Systematic Review. *Arch Suicide Res* 2016;20(1):1-21. doi:10.1080/13811118.2015.1004494
21. Nisbet PA, Duberstein PR, Conwell Y, Seidlitz L. The effect of participation in religious activities on suicide versus natural death in adults 50 and older. *J Nerv Ment Dis* 2000;188:543-6.
22. Webb M, Charbonneau AM, McCann RA, Gayle KR. Struggling and enduring with God, religious support, and recovery from severe mental illness. *J Clin Psychol* 2011;67(12):1161-76. doi:10.1002/jclp.20838.
23. Rasic D, Robinson JA, Bolton J, Bienvenu OJ, Sareen J. Longitudinal relationships of religious worship attendance, and spirituality with major depression, anxiety disorders, and suicidal ideation and attempts: findings from the Baltimore epidemiologic catchment area study. *J Psychiatr Res* 2011;45:848-854.
24. Cole-Lewis YC, Gipson PY, Opperman KJ, Arango A, King CA. Protective Role of Religious Involvement Against Depression and Suicidal Ideation Among Youth with Interpersonal Problems. *J Relig Health* 2016;55(4):1172-88. doi:10.1007/s10943-016-0194-y.
25. Recommendations for psychiatrists on spirituality and religion. Position Statement PS03/2013, November 2013. This position statement was written by Professor Christopher C. H. Cook on behalf of the Spirituality and Psychiatry Special Interest Group.
26. Curlin FA, Odell SV, Lawrence RE et al., The Relationship Between Psychiatry and Religion Among U.S. Physicians, *Psychiatric Services* 2007;58(9):1193-8.
27. Mowla A, Dastgheib SA, Jahromi LR. Comparing the Effects of Sertraline with Duloxetine for Depression Severity and Symptoms: A Double-Blind, Randomized Controlled Trial. *Clin Drug Investig*. 2016;36(7):539-43.
28. Pargament KI, Lomax JW. Understanding and addressing religion among people with mental illness. *World Psychiatry* 2013;12:26-32.

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