

Samuel Pfeifer
Ursula Waelty

Psychiatric Clinic Sonnenhalde,
Basel, Switzerland

Psychopathology and Religious Commitment – A Controlled Study

Abstract

The relationship between psychopathology and religious commitment was explored in a group of psychiatric patients (n = 44) with depression, anxiety disorders and personality disorders, compared with a control group of healthy subjects (n = 45). Neuroticism and the degree of religious involvement were measured in all probands. The findings did not show any correlation between neuroticism and religiosity. While life satisfaction was negatively correlated with neuroticism, there was a significantly positive correlation with religious commitment. Anxiety concerning sexuality, superego conflicts and childhood fears of God was primarily associated with neuroticism and not with religious commitment. The findings support the clinical observations that the primary factor in explaining neurotic functioning in religious patients is not their personal religious commitment but their underlying psychopathology.

Research on the relationship between religious commitment and psychopathology has brought forth mixed findings. Bergin [1] conducted a broad meta-analysis and found that 23% of the studies reported a negative relationship, 47% reported a positive relationship, and 30% reported no relationship at all between religion and mental health. In an extensive review of the empirical literature [2], the authors divided the available publications into three sections: A positive influence of religion was found in the area of mental health, regarding well-being, divorce rate and

marital satisfaction, depression and suicide, drug and alcohol use as well as delinquency. Ambiguous or complex associations between religion and mental health were found in the areas of anxiety, sexual disorders, psychosis, self-esteem and prejudice. Finally, religion was associated with psychopathology in the area of authoritarianism, suggestibility/dependence, dogmatism/tolerance of ambiguity/rigidity. In a recent overview of the research reported in two major psychiatric journals the authors [3] found a positive influence on mental health in 72% of the studies, neu-

tral findings in 12% and negative effects in 16%. Various reviewers [4, 5] concluded on the basis of the diversity of the data that there was little or no basis for positing any relationship between religion and mental health.

Despite this lack of empirical support, different value perceptions have led to psychological criticism of religion as an expression or the cause of psychopathology [6]. Freud [7] coined the term of religion as a 'universal obsessional neurosis'. Various German authors [8-10] attributed affective and anxiety disorders, personality disorders as well as sexual dysfunctions and deviations, to the religious background of their patients. The major difference between the two views of religion and psychopathology seems to be methodological: The assertion of the pathogenic influence of religion on mental health is primarily based on analytically oriented single case studies and rather value-oriented nonempirical observations [11]. Only rarely did empirical research support a positive correlation between psychopathology and religiosity [12]. The second notion of lacking support for the interrelation of psychopathology and religion has been better explored by empirical research. Francis and Katz [13], in an exhaustive review of the empirical studies, concluded 'that no significant relationship exists in either direction between neuroticism and religiosity' [p. 154].

Research on the interactions of religion and neurosis has been complicated by the introduction of the DSM-III and the ICD-10 which have brought major changes in the diagnosis of mental disorders, largely abandoning the term 'neurosis' [14]. However, the psychiatric conditions that were described as 'neuroses' still exist, albeit under different labels [15]. British and Australian researchers [16, 17] have been able to demonstrate the validity of the neurotic concept despite the change in diagnostic criteria. Andrews et al. [18] found a

'general neurotic syndrome' in six psychiatric syndromes (major depressive episode without psychosis or melancholia, dysthymia, obsessive-compulsive disorder, social phobia, panic with and without agoraphobia, and generalized anxiety disorder). Among other tests that were used in their study, the Eysenck Personality Inventory (EPIN) [19] proved to be a sensitive and valid instrument to measure the degree of neuroticism.

The EPIN was also frequently used to explore the relationship of personality and religiosity [20, 21]. Most of these studies were conducted with apparently healthy subjects. However, to our knowledge, there are no studies with patients currently in psychiatric care. The present study was designed to examine the correlation of religious commitment and neuroticism in psychiatric patients with an established diagnosis of depression, anxiety disorders and personality disorders.

Method

Inventories

A 51-item inventory was constructed, containing the 20 items of the Allport-Ross Religious Orientation Scale [22, 23], measuring extrinsic (11 items) and intrinsic religiosity (9 items). In addition, we chose 15 items from two previous German studies on neurosis and religiosity [24] and on depression and religiosity [25] to explore religious attitudes, beliefs and practices. The *level of religiosity* was computed from 15 items which were weighted for their significance in expressing religiosity. Nine items that reflect broad social conventions (i.e. 'I am a religious person', 'I believe in God') were given 1 point each. Five items were multiplied by a factor of 2 as they showed more specific aspects of high religiosity and reflected special religious practices (e.g. regular church attendance, praying before eating, consultation of a Christian counsellor, belief in demonic causes of disease). The computed scores (between 0 and 20) were then used as a basis to divide the subjects into two levels of religious commitment: low religiosity (≤ 11 points), and high religiosity (>11 points). 14 items addressed various questions regarding general life satisfaction, attitudes toward sexuality, religious education, religious causal attribu-

Table 1. Demographic properties of the sample (n = 89)

	Patients (n = 44)	Controls (n = 45)
Gender		
Male	13 (30)	17 (38)
Female	31 (70)	28 (62)
Age	34.41 ± 10.14	36.56 ± 16.30 ¹
Social status		
Social class I and II	8 (18)	12 (27)
Social class III–V	36 (82)	33 (73)
Marital status		
Single	18 (41)	23 (51)
Ever married	26 (59)	22 (49)
Educational level		
University degree	2 (5)	2 (4)
A level ('Matura')	7 (16)	11 (24)
High school/trade	25 (57)	28 (62)
Unqualified	10 (24)	4 (9)
Diagnostic groups		
Mood disorders	29 (66)	not applicable
Anxiety disorders	8 (18)	
Personality disorders	7 (16)	
Severity of neurotic disorder		
Mild	14 (32)	not applicable
Moderate	16 (36)	
Severe	14 (32)	
Neuroticism (EPIN)	15.54 ± 4.81*	10.02 ± 3.86 ¹
Extroversion (EPIN)	10.82 ± 4.12	11.18 ± SD 4.24

Values in parentheses are percentages.

* $p < 0.001$; all other group differences: NS.

¹ Values are mean ± SD.

tions. To measure neuroticism the Eysenck Personality Inventory (German version: [26]) was administered to all patients and controls.

Subjects

The study sample (n = 44) was derived from patients aged 18–65 years (mean 34.4 years, SD 10.14) who were treated at the Psychiatric Clinic Sonnenhalde. The clinic is treating a high proportion of religious patients as its concept allows for an integration of psychiatry and Christian counselling, while at the same time being included in the regional network of psychiatric institutions of Basel and its suburbs. Diagnoses were established according to the DSM-III-R

[27] by the first author. Patients with organic disorders, schizophrenia and major depression with psychotic features or melancholia were excluded. The severity of the condition was coded 1–3, according to the following three items: (a) Current medical or psychotherapeutic treatment for psychological problem; (b) former hospitalization for psychological problem; and (c) problems at work (loss of job, change of job because of psychological problems). Of the 50 patients who consented to fill in the questionnaires, 6 had to be excluded, 1 case because of incomplete data and 5 cases because of a Lie Score > 5 in the EPIN.

The control group (n = 45, mean age 36.56, SD 16.30) was recruited from apparently healthy membe

Table 2. Religious variables of patients and controls

	Patients (n = 44)	Controls (n = 45)
Religiosity score	14.32 ± 5.28	13.78 ± 4.60 ¹
Low (≤ 11)	10 (22.7)	10 (22.2)
High (> 11)	34 (77.3)	35 (77.8)
Average religiosity scores depending on diagnosis (NS)		
Mood disorders	14.61 ± 5.92	
Anxiety disorders	14.38 ± 4.14	
Personality disorders	13.25 ± 4.17	
Intrinsic relig.	6.41 ± 2.54	6.82 ± 2.23 ¹
Low (≤ 11)	2.50 ± 1.43	3.60 ± 2.22
High (> 11)	7.56 ± 1.35	7.74 ± 1.09
Extrinsic relig.	2.77 ± 1.60	2.76 ± 2.14 ¹
Low (≤ 11)	4.40 ± 1.84	4.60 ± 1.96
High (> 11)	2.29 ± 1.17	2.23 ± 1.91
Church affiliation		
Catholic	6 (14)	5 (11)
Protestant	38 (86)	40 (89)

Values in parentheses are percentages.

¹ Values are means ± SD.

of a choir, a bible study group and among students at Basel university. Care was taken to ascertain a sample matched in terms of the level of religiosity, social and educational status. Control subjects were given the same questionnaires as the patient group. Of the 50 persons who completed the questionnaires, 2 had to be excluded because of a Lie Score >5 in the EPIN, and 3 because they indicated mental health problems (severity of problem >0). Statistical analysis was carried out using the SPSS statistical package.

Results

On the basis of their religious commitment score (REL), patients and subjects were divided into four groups: (a) Patients with low REL (n = 10); (b) patients with high REL (n = 34); (c) controls with low REL (n = 10), and (d) controls with high REL (n = 35).

There was a substantial difference in neuroticism (NEU) between the patient group

and the controls, confirming the clinical diagnosis of psychopathology. On the other hand, the construct of extroversion did not yield a significant distinction between the groups (only mildly higher extroversion in the control group). Demographic and diagnostic data of the two groups are described in table 1.

Although all subjects and controls were nominally affiliated with a church, they showed a broad variety of religious commitment scores, ranging from 0 to 20 (mean 14.05, SD 4.93). Statistical tests of REL scores yielded good correlations of our questionnaire with other measures for religiosity, especially a highly positive correlation with the intrinsic factor ($R = 0.8821$, $p < 0.0001$) and a negative correlation with the extrinsic factor ($R = -0.4798$, $p < 0.0001$). There was no significant difference in religiosity scores between the three diagnostic groups. Religious variables of both groups are described in table 2.

Table 3. Neuroticism (mean \pm SD) in patients and controls with high and low religiosity

Groups	Patients with high religiosity (n = 34)	Patients with low religiosity (n = 10)	Controls with high religiosity (n = 35)	Controls with low religiosity (n = 10)
Neuroticism	15.59 \pm 4.58	15.40 \pm 5.76	10.09 \pm 4.06	9.80 \pm 3.22
	$\chi^2 = 0.2738$, d.f. = 1, p = 0.92		$\chi^2 = 0.6349$, d.f. = 1, p = 0.84	

Odds ratio for neuroticism in highly religious subjects (patients and controls): 1.0223 (95% confidence bounds: 0.80994–1.29054), NS.

Odds ratio for neuroticism in low religiosity subjects (patients and controls): 0.92727 (95% confidence bounds: 0.42261–2.03458), NS.

Table 4. Correlations of neuroticism and religiosity with religious education, attitudes toward various areas of interest

	Patients (n = 44)		Controls (n = 45)	
	neuroticism	religiosity	neuroticism	religiosity
Neuroticism		-0.0198		-0.0969
Life satisfaction	-0.3977**	0.3972**	-0.1718	0.2561
Religious education (Q19)	0.1181	0.0954	0.3618*	-0.2062
Childhood fear of God (Q23)	0.0369	-0.0925	0.4912**	-0.0845
Conscience sometimes annoying (Q11)	0.3858**	-0.2225	0.1727	0.1834
Anxiety concerning sex (Q22)	0.0386	-0.1081	0.3903**	0.1220
'Religion can make a person sick' (Q48)	-0.3208*	0.2119	-0.2117	0.1129
Religion more burden than support (Q49)	-0.0666	-0.2883	0.0782	0.0074
Emotional problems make practice of religion difficult (Q40)	0.0956	0.3429*	0.2225	-0.1271

* p < 0.05; ** p < 0.01.

The central question of the study, the interrelation of neuroticism and religious commitment had to be answered in the negative: *No significant difference* could be found between subgroups of high and low REL, neither within the patient sample nor within the control group (table 3).

Statistical analysis of the odds ratio for neuroticism in highly religious subjects (patients and controls) yielded no significant risk

of higher neuroticism in highly religious individuals.

Several of the additional items in our questionnaire yielded significant correlations with NEU or REL, either in the patient group or in the control group, but in no instance in both groups. *General life satisfaction* was negatively correlated with NEU, but positively with REL in the patient group. A similar tendency was found in the control group, but di

not reach significance. *Superego conflicts* ('annoying conscience') were positively associated with NEU in the patient group but negatively with REL. *Anxiety concerning sexuality* did not correlate with NEU nor REL in the patient group, however there was a significant correlation with NEU in the control group and a nonsignificant correlation with REL. Table 4 gives an overview of correlations concerning some key questions of our study.

Discussion

Empirical studies on the interrelations of religiosity and psychopathology have their limitations. The first is the problem of measurement [28] as religiosity in its broad phenomenological diversity is difficult to operationalize. Religion as a cultural phenomenon requires the adaptation of scales to the regional and denominational particularities without losing sight of common factors of religious functioning. The good correlations with the intrinsic/extrinsic scale of Allport and Ross [22] support the validity of our measurement. A second limitation of the study is the restriction to Christian religiosity. The conclusions, therefore, cannot be uncritically transferred to other religious cultures. However, there are indications for comparable validity of the findings, at least for an Israeli sample [13].

General life satisfaction was negatively correlated with neuroticism, but positively with religious commitment in the patient group. Religion thus seems to be an important factor in coping with depression and anxiety. This is especially true in the area of meaning and hope that goes beyond the actual life situation. In the control group, neuroticism (as an index of personal suffering) was too low to yield significant correlations with life satisfaction and a sense of meaning.

One of the major features of neurotic functioning is anxiety. This does not only relate to coping with life in general (such as interpersonal relations, a sense of being accepted or a sense of mastery), but also to the religious life. The conflict between cultural demands and personal drives and desires is strongly influenced by the framework of reference in the individual patient. If cultural demands are religious, neurotic conflicts and anxieties will also be expressed in a religious way. It was therefore interesting to look at correlations of areas that were attributed to religion in the literature on psychopathology associated with religion, especially anxieties related to sexuality, conscience and childhood fears of God. These three items were in no instance related with religious commitment, however, we found significant correlations with the degree of neuroticism. While superego conflicts ('annoying conscience') were significantly correlated with neuroticism in the patient group, there were high correlations of childhood fears of God and of anxiety concerning sexuality with neuroticism in the control group. In no case was there a significant correlation with the degree of religious commitment.

We interpreted the marked difference between the patient group and the clinically healthy control group as an indication for different ways of causal attributions, values and conflict resolution in the area of religion, depending on the severity of psychological suffering. Individuals who are not struggling with the existential suffering of depression and anxiety, tend to experience religion in a different and potentially more conflicting way. Gartner et al. [2] had already pointed out the difference between healthy subjects (e.g. students) filling out paper-and-pencil tests on theoretical constructs and 'real life' patients with marked pathology that could be reliably observed and measured. This could also pertain to a conflicting perception of religious

education. While there was no significant correlation with neuroticism in the patient group, the control group indicated a high correlation, thus raising further questions on functional and dysfunctional roles of religion and of religious education [29, 30]. Healthy subjects tend to experience the conflict between religious values and cultural limitations in opposition to their personal wishes, needs and drives, and they often tend to blame their inner conflicts on those limitations that might be represented by religious parents or authorities. In contrast, patients with mental and physical illness derive comfort, meaning and hope from religion, helping them to cope with their limitations [31], resulting in a negative correlation between religiosity and psychopathology [32].

In conclusion, the notion that religion exerts a negative influence on mental health in patients was not generally supported by our findings. Although the results do not allow any conclusions regarding causality, there is an indication that subjects with neurotic tendencies have a higher conflict potential in various areas of life, including religion. The primary factor in patients who display religious conflicts and anxieties seems not to be the degree of religious commitment itself but rather their underlying psychopathology [33].

Acknowledgement

The authors wish to thank the IRP (Institut für Religionspsychologie und Religionspsychopathologie Langenthal, Switzerland) for its support.

References

- 1 Bergin AE: Religiosity and mental health: A critical reevaluation and meta-analysis. *Prof Psychol Res Pract* 1983;14:170-184.
- 2 Gartner J, Larson DB, Allen GD: Religious commitment and mental health: A review of the empirical literature. *J Psychol Theol* 1991;19:6-25.
- 3 Larson DB, Kimberly AS, Lyons JS, Craigie FC, Thielman SB, Greenwood MA, Larson SS: Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry 1978-1989. *Am J Psychiatry* 1992;149:557-559.
- 4 Levin J, Vanderpool H: Is frequent religious attendance really conducive to better health? Toward an epidemiology of religion. *Soc Sci Med* 1987;24:589-600.
- 5 Sanua VD: Religion, mental health, and personality: A review of empirical studies. *Am J Psychiatry* 1969; 125:1203-1213.
- 6 Houts AC, Graham K: Can religion make you crazy? Impact of client and therapist religious values on clinical judgments. *J Consult Clin Psychol* 1986;54:267-271.
- 7 Freud S: The future of an illusion; in Strachey J (ed and transl): *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (1927). London, Hogarth, 1961, vol 21, pp 1-56.
- 8 Schaezting E: Die ekklesiogenen Neurosen. *Wege zum Menschen* 1955;7:97-108.
- 9 Thomas K: Lebensmüdenbetreuung als Behandlung «ekklesiogener» Neurosen; in Thomas K (ed): *Handbuch der Selbstmordverhütung*. Stuttgart, Enke, 1964, pp 299-331.
- 10 Thomas K: Sexualstörungen infolge «ekklesiogener» Neurosen. *Sexualmedizin* 1989;18:382-387.
- 11 Ellis A: *The Case against Religion*. New York, American Atheist Press, 1982.
- 12 Biegel K, Lester D: Religiosity as a psychological disturbance. *Psychol Rep* 1990;67:874.
- 13 Francis LJ, Katz YJ: The relationship between personality and religiosity in an Israeli sample. *J Study Rel* 1992;31:153-162.
- 14 Bayer R, Spitzer RL: Neurosis, psychodynamics, and DSM-III: A history of controversy. *Arch Gen Psychiatry* 1985;42:187-196.
- 15 Schuetzwohl M, Haefner-Ranbauer W: Verzicht auf die Unterscheidung zwischen endogener und neurotischer Depression: Verliert prognostische Information? *Fundam Psychiatr* 1993;7:109-115.
- 16 Tyrer P, Casey PR, Seivewright: Common personality features in neurotic disorder. *Br J Med Psychol* 1986;59:289-294.
- 17 Andrews G: Stressful life events and anxiety; in Burrows G, Noyes Roth M (eds): *Classification, Etiological Factors and Associated Disorders. Handbook of Anxiety*, vol Amsterdam, Elsevier, 1988.

- 18 Andrews G, Stewart G, Morris-Yates A, Holt P, Henderson S: Evidence for a general neurotic syndrome. *Br J Psychiatry* 1990;157:6-12.
- 19 Eysenck HJ, Eysenck SBG: *Manual of the Eysenck Personality Inventory*. London, University of London Press, 1964.
- 20 Robinson TN: Eysenck personality measures and religious orientation. *Pers Individ Diff* 1990;11:915-921.
- 21 Francis LJ, Pearson PR: Religiosity and the short-scale EPQ-R indices of E, N and L, compared with the JEPI, JEPQ and EPQ. *Pers Individ Diff* 1988;6:397-398.
- 22 Allport GW, Ross JM: Personal religious orientation and prejudice. *J Pers Soc Psychol* 1967;5:432-443.
- 23 Donahue MJ: Intrinsic and extrinsic religiousness: Review and meta-analysis. *J Pers Soc Psychol* 1985;48:400-419.
- 24 Hark H: *Religiöse Neurosen: Ursachen und Heilung*. Stuttgart, Kreuz, 1984.
- 25 Doerr A: *Religiosität und Depression*. Weinheim, Deutscher Studien Verlag, 1987.
- 26 Eggert D: *Eysenck-Persönlichkeits-Inventar E-P-I (1974)*. Handanweisung für die Durchführung und Auswertung, ed 2. Göttingen, Hogrefe, 1983.
- 27 American Psychiatric Association: *Diagnostic and statistical manual of mental disorders*, ed 3 revised. Washington, American Psychiatric Association, 1987.
- 28 Gorsuch RL: Measurement: The boon and bane of investigating religion. *Am Psychol* 1984;39:228-236.
- 29 Spilka B: Functional and dysfunctional roles of religion: An attributional approach. *J Psychol Christianity* 1989;8(3):5-15.
- 30 Ringel E: *Religionsverlust durch religiöse Erziehung*. Tiefenpsychologische Ursachen und Folgerungen. Vienna, Herder, 1985.
- 31 Koenig HG, Cohen HJ, Blazer DG, Pieper C, Meador KG, Shelp F, Goli V, DiPasquale B: Religious coping and depression among elderly, hospitalized medically ill men. *Am J Psychiatry* 1992;49:1693-1700.
- 32 Stark R: Psychopathology and religious commitment. *Rev Rel Res* 1971;12:165-176.
- 33 Meissner WW: The phenomenology of religious psychopathology. *Bull Menninger Clin* 1991;55:281-298.