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ORIGINAL ARTICLE

RELIGION AND CHILDHOOD EXPERIENCES OF PSYCHIATRIC VOICE HEARERS

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ABSTRACT

Objective: to analyze the relationship between childhood experiences of voice hearers and religion as an adult. Method: cross-sectional research with voice hearers from a Psychosocial Care Center in a city in the interior of Rio Grande do Sul, Brazil. Data collection occurred in 2019 using standardized questionnaires; for the variables on religion, the Duke Religious Index questionnaire was used. For data analysis, absolute frequencies, proportions, and bivariate analysis were used. Results: 112 people participated, of these, 66 reported hearing voices, 65% reported having religion, with a higher prevalence of evangelicals (n=31; 52%). Not having a pleasant childhood (78%), having experienced a stressful childhood (76%) and not having felt safe on the streets as a child (83%) were related to having religion as an adult. Conclusion: this study proposes a change in knowledge production and care in mental health that considers experience and religiosity.

DESCRIPTORS: Religion; Mental Health; Life Change Events; Adult Survivors of Child Adverse Events; Hallucinations.

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INTRODUCTION

The relationship between religion and health care is rooted in history. The first Western hospitals, including psychiatric ones, originated in religious institutions. The split occurred with the development of psychiatry, especially psychoanalysis, with writings on religion spread by Freud in the 1980s. However, studies on this theme have grown significantly again since 2000, 80% of them in the field of mental health[1].

There is a positive relationship between religion, religiosity and spirituality and states of well-being and mental health[1-3], besides being a coping strategy for traumatic experiences[4]. Research involving psychiatric populations indicates that religious factors also affect the trustworthiness, treatment expectancy, and quality of life of people with psychotic disorders. Trust in God has been shown to be associated with fewer psychiatric symptoms and greater hope for treatment[5].

Religious practices were also shown to reduce the risk of suicide in a large-scale North American cohort study, which found that women who participated at least once a week in religious meetings had their risk of suicide reduced by more than five times. However, religiosity is multidimensional, and its aspects may be variously associated[6].

At the same time, it is possible that traumatic experiences drive the search for a spiritual path, because people with higher scores of anxieties, depression, and trauma seem to turn more to spirituality. People with more traumatic events in their lives spend more time on spiritual activities[7].

In the context of hearing voices, the literature makes a consistent relationship between childhood trauma and hearing voices, contributing to the perspective that people with a history of traumatic events in life are more likely to hear voices. It is added that spiritual beliefs may contribute to ways of coping with the experience of hearing voices[8-10].

However, generally, these three issues are not studied in an associated manner, namely: traumatic experiences in childhood, hearing voices, and the presence of religion in adult life. It is believed that the voice hearers, due to the higher probability of having experienced trauma in childhood, have more marked religious aspects in their life context as adults. Therefore, developing a study that considers the triad religion, childhood experiences and hearing voices can bring new perspectives to the understanding of this theme.

Added to this issue is the religious dimension that, despite being little considered in the scope of professional practices, is inevitable, since it integrates the human experience. Thus, it can contribute to the clinical conducts, besides composing the social and support network, respecting the individual beliefs of people[11]. Therefore, considering religion in clinical practice can be a resource for facing traumas and difficult experiences in life, including the challenge of experiencing voices.

Considering the above, the present study sought to analyze the relationship between the childhood experiences of voice hearers and religion as an adult.

METHOD

This is a cross-sectional study involving psychiatric voice hearers. It consists of an unfolding of the research entitled: "Voices ombudsmen - new approaches in mental health", developed in two stages. The first, between September 2017 and May 2018 by reviewing all the medical records of users of a Psychosocial Care Center (CAPS) II in the city of

Pelotas-RS, Brazil. A total of 400 medical records of active users in the service were found. Of this total number of users, 11 did not present complete information, which resulted in the inclusion of 389 users.

The second stage of data collection occurred between February and March 2019, and 172 medical records with records of hearing voices were identified. The exclusion criteria used were having a diagnosis of mental retardation and not currently attending CAPS II. Forty-six users with records of hearing voices who met at least one of these criteria were removed from the sample. Of the 126 users elected as possible participants in the research, 112 accepted to take part in the study, resulting in a rate of 9% of losses and refusals (n=14).

Standardized and validated questionnaires were used for data collection, carried out through interviews conducted by properly trained graduate students. For the variables on religion, we used the Duke Religious Index questionnaire translated by Moreira - Almeida et. al (2008). The interviews were previously scheduled with the users and carried out in the same space where the service is developed, in the mornings and afternoons from Monday to Friday. For users who were unable to attend CAPS, the interviewers conducted searches and interviews at home, representing the last stage of data collection.

To collect the outcome in this study, the dichotomous variable has religion was adopted, with response options yes, no. The following were analyzed in relation to the outcome: gender: Male, Female; age: 21 to 31, 32 to 42, 43 to 53, 54 to 64, and 65 to 75 years old; skin color: White, Black, Brown, Yellow, Indigenous; educational level - knowing how to read and write: No, Yes; marital status/marital status: Single, Married, Separated/Divorced, Widowed; current work: No; No, but I am retired; No, but I receive benefit; Yes.

In addition, the frequencies of the nominal variables "What is your religion?"; "How often do you go to a church, temple, or other religious gathering?"; "How often do you devote your time to individual religious activities such as praying, praying, meditating, reading the Bible or other religious texts?" were described. These had as answer options, respectively: Catholic; Evangelical; Spiritualist; Umbanda/Candomblé. More than once a week; once a week; two to three times a month; a few times a year; once a year or less; Never. More than once a day; daily; two or more times a week; once a week; a few times a month; rarely or never. Those who reported including religious sessions in their routine at least once a week were considered participants in collective religious activities.

Regarding religious beliefs, three affirmative sentences were employed: (1) "In my life, I feel the presence of God (or the Holy Spirit)"; (2) "My religious beliefs are really behind the whole way I live"; (3) "I try very hard to live my religion in all aspects of life"; with response options: "totally true for me"; "generally true"; "not sure"; "generally not true"; "not true".

To verify the existence of a relationship established by the ombudsman between religious/spiritual experiences and his hearing of voices, we used the discrete nominal variable "To which experience do you relate the hearing of voices?", which presented among its response options: problems within a religious community or other spiritual sect and attending a séance, satanic ritual, spiritual event.

To analyze the relationship between current religion and the childhood experiences of the voice hearers, we used the following variables categorized as yes or no: enjoyable? stressful? safe at school? safe on the street? safe at home? fear of thieves at night? mistreatment? ...; punishment ...; belittling ...; not liked ...; not able to do anything right ...; witnessed abuse ...; had sexual intercourse against his will ...; situation in which he was not able to resist or escape ... relates his childhood experiences to hearing voices ... With the junction of the variables sexual abuse and sexual intercourse against one's will, we created the variable "sexual violence".

The data were double typed into EpiData 3.0 software, and a descriptive analysis

was performed to obtain absolute frequencies and proportions, and a bivariate analysis was performed using the chi-square test and a 5% significance level in Stata 11 software.

This study went through the Research Ethics Committee of the Faculdade de Medicina da Universidade Federal de Pelotas, RS Brazil and was approved under opinion number 2,201,138.

RESULTS

The socioeconomic profile of the listeners who had religion (Table 1) was as follows: 29 women (66%) reported having religion, as did 22 (51%) of those between the ages of 40 and 59 years old. Regarding skin color, 53% (n=23) of whites, followed by 34% of blacks and browns (n=15) reported having religion. Among the participants, 41 (90%) could read and write, 32 had no partner (74%); 28 (67%) did not work and had religion.

Table 1 - Socioeconomic profile of voice listeners and relationship with religion. Pelotas, RS, Brazil, 2017-2019 (continues)

Variables	Religion	
	No (n/%)	Yes (n/%)
Gender		
Male	8 (36)	14 (64)
Female	15(34)	29 (66)
Age		
21 to 39 years old	4 (25)	12(75)
40 to 59 years old	15(41)	22(51)
60 and older	4 (31)	9 (69)
Skin Color		
White	18(41)	23(56)
Black	1 (11)	8 (89)
Brown	4 (36)	7(64)
Yellow	0 (0)	3(100)
Indigenous	0 (0)	2 (100)
Can read and write		
No	1 (33)	2 (67)
Yes	22 (35)	41 (65)
Lives with a partner		
No	15 (36)	27 (64)
Yes	8 (33)	16 (67)
Marital status		
Single	10 (29)	24 (71)

Married	4 (27)	11 (73)
Separated/Divorced	7 (58)	5 (42)
Widower	2 (40)	3 (60)
Current Job		
No	13 (32)	28(68)
No, but I am retired	5 (50)	5(50)
No, but I receive benefit	4 (44)	5(56)
Yes	1 (20)	4(80)

Source: Authors (2019).

Among the research participants (n=112), 66 (59%) reported hearing voices at the time of the interview, which made up the sample of this study. Over 90% (n=60) of the voice hearers reported performing collective religious practices, regardless of whether they had a religion. The highest frequencies of participation were at least once a week 41 (42%), followed by never 25 (25%) participants. Of the 66 ombudsmen, one did not answer the block of questions related to childhood experiences.

Fifty-two (50%) participants reported engaging daily in individual religious activities such as praying, praying, meditating, reading the Bible or other religious texts, and 73 (70%) participants reported feeling the presence of God (or the Holy Spirit). More than half of the respondents believed that their religious beliefs were behind their entire way of life, and 46 (41%) said they tried very hard to live their religion in all aspects of life.

Thirty-six (60%) participants reported having religion. Among the participants, a greater prevalence of the Evangelical religion was found, 31 (52%), followed by the Catholic religion, 14 (24%). The religions of the Spiritualist/Umbanda/Candomblé and others totaled 14 (24%), with the loss of one respondent.

Regarding childhood experiences, not having a pleasant childhood and having lived a stressful childhood were experiences that showed a statistically significant relationship with p-value <0.05 with the fact of having a religion. Not feeling safe on the streets was also associated with religion: those who reported having a religion felt less safe on the streets as children. The other variables showed no statistically significant relation with the outcome (Table 2).

Table 2 - Relationship between childhood experiences and religion among voice hearers. Pelotas, RS, Brazil, 2017-2019 (continues)

Variables	**Religion**	
	No (n/%)	**Yes (n/%)**
Pleasant childhood p<0.05		
No	8 (22)	29 (78)
Yes	14 (50)	14 (50)
Stressful childhood p<0.05		
No	13 (48)	14 (52)
Yes	9 (24)	29 (76)

Safety at School		
No	10 (30)	23 (70)
Yes	12 (37,5)	20 (63,5)
Safety on the street p<0.05		
No	5 (17)	25 (83)
Yes	18 (51)	17 (49)
Home Security		
No	8 (31)	18 (69)
Yes	15 (37,5)	25(62,5)
Fear of Thieves		
No	9 (32)	19 (68)
Yes	14 (37)	24(63)
Mistreated		
No	14 (41)	20 (59)
Yes	9 (28)	23(72)
Received punishments (being locked up or tied up)		
No	16 (35)	30 (65)
Yes	7 (35)	13 (65)
Shouted at or belittled		
No	8 (47)	9 (53)
Yes	14 (29)	34 (71)
Well liked		
No	10 (48)	11 (52)
Yes	13 (30)	31 (70)
Unable to do anything right		
No	10 (35)	19 (65)
Yes	11 (32)	23 (68)
Witnessed mistreatment		
No	12 (41)	17 (59)
Yes	11 (30)	26 (70)
Sexual Violence		
No	14 (33)	28 (67)
Yes	8 (35)	15 (65)
Unable to resist or escape		
No	13 (41)	19 (60)
Yes	10 (30)	23 (70)
Relates the fact of voices to childhood		
No	13 (43)	17 (57)
Yes	9 (27)	24 (73)

Bivariate analysis using chi-square test. Source: Authors (2019).

DISCUSSION

According to the Brazilian Institute of Geography and Statistics (IBGE)[12], Brazil is a country in which 89% of the general population declared religion in the last census with a representation of 59% Catholics, 29% Evangelicals and 12% Spiritualists for the city of Pelotas-RS. In this study, we found a prevalence of 65% of listeners with religion, with a greater presence of the evangelical religion (52%). A higher prevalence of participants reported having no religion, and the prevalence of Catholics is lower compared to national data(12) and studies in psychiatric populations[13-14].

In a study from the state of Santa Catarina, it was verified that 93% of the people in psychiatric treatment have religion, with the highest percentage of Catholics (49%), followed by Evangelicals (34%)[13]. The highest prevalence of Catholics (54%) was also identified in a study from São Paulo[14].

The greater presence of the evangelical religion in this sample may reflect the growth of this religious trend already signaled in the period 2000-2010[12] or be the expression of the concealment of other strands, since the prevalence of having a religion was lower in this sample when compared to other studies[12-13]. However, the construction of religious identity suffers anthropological influences that need to be further investigated in future studies.

Of the listeners, 43% participated in organizational religious activities, and more than half of the respondents had a daily habit of doing individual religious activities. Most said they felt the presence of God (or the Holy Spirit) and had their religious beliefs as the basis of their whole way of life, and half reported making a lot of effort to do so. These data contribute to the perception that religious experiences are strongly marked in the way of life of the population in this study, because, regardless of having religion, religious rites and beliefs permeate their daily lives. It is possible that religious beliefs and practices are a resource for coping with the experience of life and illness of these people.

Organizational and regular individual religious practices, based on group doctrines, can be a support in facing situations and stress and increase social support[1]. More religious people demonstrate more meaningful and peaceful actions than less religious people and are associated with better overall health outcomes[15]. Those with higher levels of spirituality and religiosity also express better mental health status[2]. In the face of the experience of illness, faith and religiosity may represent a support by contributing to more optimistic worldviews.

This perspective is being widely discussed, but, although the spiritual/religious dimension appears in the literature as a resource for coping with illness experiences, the mechanisms involved in this process are not yet scientifically clear[11]. Some show a positive influence of religion on people's mental and physical health, but this does not mean that it always improves. Among them, it is believed that religion could offer coping resources for stressful situations and influence the cognitive evaluation of these events as less distressing[1]. In this sense, religion could serve as support for the resignification of difficult life experiences, among them, childhood traumas.

Relationships between childhood trauma and hearing voices have been frequently presented in the recent literature on psychosis, which has contributed significantly to expanding the understanding of hearing voices[8-10]. However, experiences of voices may have multiple explanatory pathways beyond trauma; one is that voices may coexist with aspects of religiosity and may even be stimulated in contexts that value this type of experience. In this case, the mechanisms involved in the existence of hallucinations do not arise from trauma, which may also affect the perception of this experience, since there is greater suffering and diversity of voices in hallucinations associated with trauma[16]. Thus, the voices may assume different senses and meanings according to the context of the

listener's life, his childhood experiences, his religious and cultural beliefs, as well as his mental health status[17].

In the present study, there was a significant relationship between some types of childhood trauma and having a religion as an adult. Among those who did not have a pleasant childhood, 78% had religion, as well as 76% of those who had a stressful childhood, and 83% who felt unsafe on the street. These results lead us to believe that religion may represent a strategy adopted by these listeners to face traumatic aspects experienced in childhood. One possible explanation is that religion/spirituality would be able to influence the psychological adaptation of people with adverse and stressful experiences in life[3,18].

A study on the role of religious coping and the health of adult survivors of early traumatic stress found that even at low exposure to the traumatic event, the physical and mental health of these people is significantly negatively affected. It was also identified that positive religious coping as well as the development of positive virtues such as forgiveness, gratitude, positive religious coping, and religiosity appear to be important factors in reducing the negative impact of the traumatic experience on mental health[4].

Thus, health outcomes seem to be mediated also by the type of religious coping, positive or negative. However, such findings show the need for studies that analyze the pattern of religious coping of voice hearers, considering that these may have distinct implications, positive and/or negative. They affect, in some way, both the health and the ability of the individual to adapt to stressful situations in how to deal with traumas, with one's own health and with the experience of hearing voices.

In this sense, aware that mental and physical health is affected, in some way, by religion/spirituality, not including this relationship in clinical approaches will certainly affect medical outcomes[1]. For, the therapeutic process of a person experiencing hearing voices is intertwined with the numerous aspects of human existence. Religion/spirituality as well as childhood experiences is one of many dimensions involved in the listener's meaning of voices.

The present study has some limitations. Because it is a cross-sectional approach, cause-effect conclusions need to be avoided, and a longitudinal strategy would be important to understand if listeners with traumatic childhood experiences the ones are who most frequently seek religion. Also, due to the size and specificity of the sample, generalizations should also be avoided, and the results may still be subject to relationships with unmeasured variables such as religious coping profile, beliefs about voices and traumatic events, among others.

FINAL CONSIDERATIONS

The results of this study contribute to the area of nursing and health by rethinking the practices of care to people in psychic suffering to those who hear voices with the discussion about the triad religion, experiences in childhood and hearing voices. Moreover, even with a small sample, statistically significant relationships were found between having religion in adulthood and some types of traumas in childhood, which demonstrates the need to further investigate this relationship, to know the life history of the listener and his practices beyond the mental health services to promote the integrality of care.

This study sought to analyze the relationship between religion and the childhood experiences of psychiatric voice hearers. Contrary to findings in the literature, it was identified in the sample a lower prevalence of people with religion when compared to the results found in other studies. This aspect may be related to other spaces of reception of the religious voice's listeners other than the mental health service. It was also observed a higher presence of evangelicals compared to other religious strands.

It is hoped that this will encourage professionals and the academic community to include religiosity as part of the therapeutic and research process with people who experience hearing voices that others do not hear, since it can represent a point of strength through positive religious coping or of weakness through negative religious coping.

The study contributes to the nursing and health area by reinforcing the importance of another paradigm of knowledge production and care in mental health, which considers the knowledge of experience and religiosity, and the need for these modifications in the culture in relation to the experience of hearing voices for the advancement of civilization and humanization, which considers the knowledge of the experience of each person in the relationship with the voices, religion, and childhood experiences.

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