

# 'I can't pray' - The spiritual needs of Malaysian Muslim patients suffering from depression

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## ABSTRACT

**Introduction:** The mainstay of treatment of depression relies on pharmacological and psychological treatments. On top of that, evidence also recognizes the vital role of spirituality for human wellness which leads to growing interest in its utilization to treat depression. However, research on spirituality among Muslims in relation to depression is relatively scarce. The aim of this study is to explore the understanding of spirituality among Muslim patients with depression, and to explore their spiritual needs. **Methods:** This is a qualitative study conducted on 10 depressed Muslim patients at the UKM Medical Centre. Purposive sampling was done to ensure diversity of subjects. Individual in-depth interviews were conducted using semi-structured questionnaire guidelines. The data were transcribed verbatim and analysed using a thematic approach. **Result:** Out of 10 patients, almost all of them expressed spiritual needs. Two major themes emerged in relation to the spiritual needs which are (i) religious needs; need for worship, religious knowledge and guidance, religious reminders, and (ii) existential needs; need for calmness, sensitivity and empathy, self-discipline, certainty, hope, physical help, ventilate and meaning of illness. These needs are essential for patients during the time of crisis. **Conclusion:** The majority of patients expressed spiritual needs which are required during the process of recovery and this provides an opportunity to incorporate spiritual approaches in the treatment of depression. However, more studies are needed to demonstrate its scientific basis and to design an effective psycho-spiritual treatment modality so that the 'holistic' or 'bio-psychosocial-spiritual' treatment can be integrated by health care professionals to those in need.

**KEYWORDS:** Spirituality, Depression, Muslim, Qualitative study, Unmet need

## INTRODUCTION

'I can't pray' - those were his words. Being a physically disabled man, it was hard for Ahmad to perform religious practices on his own. Diagnosed with depression, he has been hesitantly coming to meet his psychotherapist for treatment. He discovered that coping through religio-spiritual ways made him feel at ease with his condition as he was able to make sense of his suffering; it is a test from God to make him closer to Him. However this issue has never been attended to by his family, let alone discussed in any psychotherapy sessions he has

attended so far. This scenario is a good example of how essential spirituality is to some patients. Ignoring his needs will eventually result in losing him from psychiatric contact.

Spirituality has helped man greatly in coping with illness and life-stressors.<sup>1</sup> In a systematic review conducted in 2012, out of 444 studies examining the relationship between religiosity/spirituality and depression, about 60% of the studies reported less depression and faster recovery as compared to only 6% reporting the opposite result.<sup>2</sup> Some of the mechanisms proposed for religio-spiritual coping are for instance: religion and spirituality help in the discovery of meaning and purpose in one's life,<sup>3</sup> and it fosters a sense of closeness to God,<sup>4</sup> the ultimate source of help. Recognizing the importance of integrating spiritual dimension and healthcare, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) stated: "For many patients, pastoral care and other spiritual services are an integral part of health care and daily life. The hospital is able to provide for pastoral care and other spiritual service for patients who request them".<sup>5</sup>

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Despite the fact that there are vast data to suggest spirituality as a positive factor in managing psychiatric illnesses, specifically depression, we believe that spirituality has not been well addressed in clinical practice. There is still a significant number of psychiatrists who do not believe in the role of spirituality in psychiatric care.<sup>6</sup> In a study conducted among 208 Australian old-age psychiatrists, Payman<sup>6</sup> found 85% of subjects believe that there is no link between religion and mental health. In another study conducted among US physician from all specialties, only 10% was found to routinely talk to their patients about spirituality.<sup>7</sup>

Since the early 1990s, patients suffering from psychiatric illnesses have demanded spirituality-integrated treatment from psychiatrists, along with conventional biological treatment. Due to this, it has raised many questions rather than answers to the treating doctors.<sup>8</sup> While many patients want their doctors to consult their spiritual needs and discuss about it<sup>9</sup>, the reality of clinical practice in psychiatry shows otherwise.

Furthermore, a substantial amount of evidence on mental health, religiosity and spirituality were conducted in a Christian or Jewish community.<sup>10</sup> Due to the fact that spirituality and religiosity are laden with values which are beyond unison<sup>11</sup>, the applicability of these literatures to the unique Muslim-Malaysian culture is unknown. Malaysia is a multiracial and multicultural society population of 28.3 million in which 61.3% are Muslims, 19.8% Buddhists, 9.2% Christians and 6.3% Hindus.<sup>12</sup> Malaysians especially Malays, by nature are spiritual people, which received influences from animism, Hinduism, Buddhism before islamisation of the Malay.<sup>13</sup> This makes Malaysians a unique case for study. This research was conducted with the objective to explore the spiritual needs of Muslim patients, regardless of ethnicity, who were suffering from major depressive disorder.

## MATERIALS & METHODS

This study was conducted in Universiti Kebangsaan Malaysia Medical Centre (UKMMC) within an 8-month period from January to August 2015. Patients were identified from the hospital database at the department of psychiatry (in-patient and out-patient). Using purposive sampling method, maximum variability of patients in terms of age, gender, race, education, social-economic status, and duration of illness was ensured. The number of patients recruited was based on the concept of saturation point.<sup>14</sup> Patients who were previously diagnosed as major depressive disorder or persistent depressive disorder using DSM-5 criteria, aged between 18 to 65 years old and able to communicate well in Bahasa Melayu or English were included in this study. Deviant cases e.g. exposure to western culture, were also sought. Patients with severe mental disorder and dementia were excluded.

This study was approved by the ethics board committee of Universiti Kebangsaan Malaysia (UKM). Written consent and demographic data on age, gender, race, and religion were obtained before the interview. Individual semi-structured interviews were conducted at patients' homes or at UKMMC. At least three co-researchers including a qualitative expert were present during each interview. Interviews were generally conducted for 60-90 minutes. Additional interviews for further clarification were undertaken if necessary. The data were documented in the field notes, and audio data were also recorded. Debriefing sessions were held each day after the data collection sessions.

Data analysis was done concurrently along with data collection. The codes and themes based on the study objective were gathered manually. The patterns and categories of themes were continuously examined. Most of the patients' views were paraphrased while some others were quoted verbatim in order to maintain the essence of patients' feeling or expression without any interpretation. Less relevant texts were removed from the transcripts to yield data from which themes were generated.

Four key-informants; two Muslim psychiatrists, a practitioner from Dar Al'Syifa (healer), and a specialist in Malay language and culture, were interviewed to validate the findings.

## RESULTS

Variable	Number	
Gender	Male	5
	Female	5
Age	<40 year-old	3
	40-60 year-old	5
	>60 year-old	2
Race	Malay	7
	Indian	3
	Chinese:	0
Education	Primary	1
	Secondary	2
	Tertiary	7
SES	< RM 5000	5
	Rm 5000- 10,000	4
	> RM 10, 000	1

**Table II.** The categories and themes generated from this study.

Category	Theme
Knowledge and guidance	
Reminders	Religious Needs
Worship	
Calmness	
Certainty	
Hope	
Meaning of illness	Existential needs
Physical help	
Self-discipline	
Sensitivity and empathy	
Ventilation	

### 1. Socio-Demographic characteristics

A total of 10 patents were interviewed, whose ages ranged from 28 to 65 years. More than half of the patients were Malay (n= 7), followed by 3 Indian Muslims. Half of the patients earned less than RM 5000 monthly. The patients' demographic characteristics are displayed in Table I. At the end of analysis, two main categories were generated; religious and existential needs, as shown in Table II.

### 2. Religious needs

**Knowledge and Guidance.** Knowledge here is defined as patients' understanding of matters pertinent to religious obligations. While knowledge could be sought through personal endeavour e.g. reading, guidance is meant as a person who could inculcate and demonstrate knowledge and turn it into practice. Half of the patients described the need for religious knowledge and guidance as a means to understand spirituality and religious practices. It includes knowledge on concession of religious obligations while one is sick (*rukhsah*). Lack of knowledge may lead to uncertainty and eventually guilt. A 52 year-old depressed lady who is bed-ridden described:

*"I am not convinced (to pray). Because it is not clean (diapers). And if you want to pray you have to face the Qiblah. So should I turn my bed?...if I am living like this (unable to practice religion), it is better for me to die. The more I live, the more sin I will make."*

The knowledge could be disseminated through a small group discussion among patients and should be focused on individual needs. A 35 year-old Malay man explained:

*"they should have a round table discussion ...so that they get input (knowledge) from each other, so for depression we need to also give them input...You (have to) understand their social life, what they believe, what their background is...then it will be easy for you to give spiritual input..."*

Some patients described the need for religious guidance from a religious teacher during the process of acquiring knowledge, especially for those patients with poor knowledge and competency on Islam. A 65 year-old Indian Muslim man expressed:

*"Actually I just know the basic things, I just follow (people)... there was once a religious teacher, who came and gave a talk in day care for everybody...his presence helped a lot of people..."*

**Worship.** The majority of the patients described their need for worship, which could be categorized into two types; specific form of worship i.e. prayer (Solah), supplication (Dua), incantation (Zikir), recitation of Quran, and general form of worship i.e. talking to God and thinking about Him. Describing about his spiritual practices, a 43 year-old Indian man conveyed:

*"After I talk to God, I feel very calm, I feel satisfied, peaceful in mind, I ventilated and tell God what is going on, I always talk to Him, I always share with God because that makes me happy"*

Often patients experience an uncomfortable feeling if these practices could not be carried out. The same patient further continued:

*"This (spiritual practice) is the main thing that supports me. I can feel it. If I miss it, I will feel bad that day"*

### Reminders

A few depressed patients expressed the need to be reminded about their religious obligations, observing patience and remembrance of God during their time of crisis. The reminders could come from a doctor, friends or family members. A 34 year-old Malay lady voiced:

*"Sometimes when I feel depressed...at that time I could not remember Allah...if at that time a doctor or anyone else reminds me...Probably it would be helpful to me..."*

Another patient, a 65 year-old Malay widow mentioned:

*“My children came and reminded me to observe patience...it gave me strength to be patient”*

### 3. Existential needs

The following are the categories of existential needs.

**Calmness:** Some spiritual practices e.g. prayer (*solah*), contemplation of Qur’anic verses (*tadabbur*), require patients to concentrate and focus, and these could be disturbed if patients are anxious or restless. A 65 year-old Indian man and an elderly Malay lady concurred on this respectively:

*“But since now I have this restlessness, I couldn’t concentrate (in Solah)”*

*“The psychiatrist gave me medication to make me calm so that I can read Quran. I could not read if I was anxious”*

The state of calmness is attainable through the help of medications, as well as relaxation methods that require less focus e.g. talking to God.

**Physical Help:** For patients who are physically disabled, physical help is needed in order for them to carry out their spiritual practices e.g. purification (*taharah*) such as performing ablution (*wudhu*). Lack of this type of support would lead to abandonment of spiritual practices. For instance, a 52 year-old depressed lady, who suffered from severe rheumatoid arthritis and depression clarified:

*“I have generalized body ache, a lot of problems; urine (contaminate her clothes) and I feel lethargic...I need physical support from people to help perform the ablution, to wear the hijab, and to change my diapers. It is really hard...”*

**Certainty:** Certainty about one’s diagnosis, positive outcome of a treatment and certainty about the meaning of illness were important to patients. Uncertainty might deter peacefulness as mentioned by a 34 year-old Malay lady who described her need to be certain:

*“If I am not certain, I will feel doubt. It doesn’t give me tranquillity. If we are not certain, peace can never (be attained) for me... (We have to be) certain with the test from God then certain that Allah will heal it”*

This is in contrast to another patient who is uncertain about the “test” she is facing:

*“When given this kind of test, maybe... maybe there is a reason for it (unsure)...but when I think back, I can’t do it, I can’t do it at all, and I feel God is merciless to me”*

**Hope:** Hopelessness is one of the features of depression which may “clash” with one’s spiritual state. A 25 year-old Malay man explained his need to have hope. The apparent clash between hope and hopelessness could be reconciled through psychotherapy:

*“When we have depression, sometime we lose hope in Allah, this one (hope to Allah) and this one (hopelessness) will clash with each other”*

In another instance he mentioned:

*“It was terrible and sometime I lost hope in Allah, because it is a very hard trial, then when I met a clinical psychologist, she taught me to how to think positively”*

Hopelessness could be a result of a perceived impiety upon committing sinful activities in the past. A 65 year-old Indian man expressed:

*“I feel everything is late for me, frankly everything is too late for me...now I feel fear, you know, because I didn’t pray and (now) I am being punished...”*

**Sensitivity and Empathy:** During the time of crisis, patients require empathy and other people’s sense of sensitivity towards one’s suffering. These are needed from significant others including doctors and family members as described by these two patients; a 52 year-old Malay lady and a 25 year-old Malay man respectively:

*“When I think back, if my life on earth is like this, in the hereafter I will get more severe punishment. I need support from my family members. They only scold me”*

*“He (first doctor) has empathy...but the other doctor is just simply like ‘I have a clinic now and I am checking you and I just want to know whether you are taking any medications”*

The sensitivity is not limited to one’s suffering but also related to one’s spiritual or religious belief. A 35 year-old Malay man suggested:

*“You (have to) understand their social life, what they believe, what their background is...then it will be easy for you to give a spiritual input...”*

**Self-discipline:** A patient is said to have self-discipline if he has the ability to carry out a task that he is supposed to do. Self-discipline was mentioned in terms of the efforts taken to seek proper treatment. A 34 year-old Malay lady

described:

***“Allah said in the Quran and Hadith every disease has its cure. If I have the suitable medication inshallah (if Allah wills), Allah will heal it...Meaning we have to make an effort to heal our diseases... We must know everything that Allah created, like doctors, are intermediaries for us to heal. Doctors are intermediaries that Allah sent to us”***

This is in contrast to passivity and inactivity in seeking treatment. The same person continued:

***“God tell us to make an effort... (There is no point) if you just sit and pray without effort”***

Passivity and inactivity could be influenced by patients' understanding of the illness and education level.

**Ventilate:** Ventilation is an act of verbalizing one's emotion or feelings to a significant other; God, doctor, staff nurses, family members or friends. Patients would feel relief upon doing it. A 65 year-old Malay lady shared:

***“I feel relieved, I have talked to Him. Previously I could share (my problems) with my late husband, now with my children...I feel better to share with God...”***

**Meaning of illness:** The meaning of an illness or event is important for patient to make-sense of his or her suffering, for instance a 34 year-old Malay lady stated:

***“His purpose is a process to nurture and educate his servant”***

This is in contrast to a 25 year-old Malay lady who used to whine about her problem, which exposed the lack of meaning in herself:

***“People always say that... okay fate taqdir, yes I do believe thing happen for a reason but, I can't join the dot, I can't see that...”***

## DISCUSSION

The need for worship was mentioned by almost all patients as expected. These religious practices e.g. *solah*, *dua*, and recitation of the Quran, are some examples of how people sustain their relationships with the sacred.<sup>15</sup> Hatamipour and others found similar findings among Muslim cancer-stricken patients in Iran who believed that prayer and communication with God are a part of their spiritual needs.<sup>16</sup> In contrary, patients living in secular societies score lower religious need (i.e. praying,

religious ceremony) as compared to non-religious need.<sup>17</sup> This is due to the fact that Islam is deeply enrooted in the lives of many Muslims.<sup>18</sup> There is little distinction between spirituality and religiosity in Muslim societies, as secularization in these communities has not been so extensive as compared to Christianity in the west.<sup>11</sup>

It is worth to note that the need for calmness is vital for some patients in order to maintain spiritual connections through the act of worship e.g. *solah*. The use of benzodiazepines and anti-depressants help patients to be calm.<sup>19</sup> The known positive effects of Quranic recitation on anxious patients<sup>20</sup> can be used as an alternative to pharmacological intervention since it fulfils both patients' need for worship as well as need for calmness. However, further evidence is needed to substantiate its use for patients with depression.

The next most mentioned need by our patients was the need for religious knowledge and guidance. The need for knowledge was discussed by Karimollahi and others, upon examining the spiritual needs of hospitalized Iranian patients.<sup>21</sup> The findings regarding need for knowledge, however, were only related to the need for knowledge of the illness, with no mention of religion. As noted in the findings, among the reasons given by patients on why they did not perform prayers (*solah*) were; lack of knowledge and guidance on the concession of religious obligations (*rukhsah*), and immobility. This finding is substantiated by another study exploring the knowledge and practice on prayer (*solah*) among in-patients in Malaysia.<sup>22</sup> Both knowledge and discipline (as will be described below) are two major component of Iman Restoration Therapy (IRT) theorized by Abdul Razak et al, which is potentially useful to be used in psycho-spiritual therapy among Muslims.<sup>23</sup>

To the author's knowledge, the need for self-discipline among patients was not discussed in any previous literature. Discipline (*Riyadah*) means a process where the inner soul of a man is gradually trained to transform negative traits into good characters and behaviours<sup>23</sup> e.g. seeking proper treatment for an illness. The combination of self-discipline with reliance on God's collaborative intervention is known as *tawakkul* (Quran 2:159-160). This is similar to collaborative spiritual coping as defined by Pargament and others.<sup>24</sup> In contrast, fatalistic thinking characterized by inaction and passive acceptance<sup>25</sup> is associated with hopelessness and anxious preoccupation.<sup>26</sup> Often fatalistic thinking (*tawaakul*) is associated with misunderstanding of Islamic doctrine of predestination (*al-qadr*) due to misinterpretation of some Qur'anic verses which often occurs in the case of uninformed patients.<sup>25</sup>

A few patients suggested that the psychiatrist should 'remind' them about their religious values

and obligations when they were depressed as a part of the treatment. There are a few concerns on this i.e. risk of offense, subtle coercion and role confusion by the psychiatrist.<sup>27</sup> Despite that, there are a few guidelines available for psychiatrist to prescribe religious intervention i.e. (1) to respect the patient's autonomy (2) sensitivity and empathy for the patient's spiritual belief and (3) responsiveness to the patient's spiritual belief.<sup>28,29</sup> The need for sensitivity for patient's spiritual belief was described quite clearly by our patients in the result section.

It is intriguing to note that the need for hope was discussed by a number of patients. Hope is negatively associated with negative symptoms.<sup>30</sup> The question of hope (*raja'*) and fear (*khawf*) has been discussed extensively by Islamic theologians. The faith of a Muslim believer lies in between fear of God (*khawf*) and hope in God (*raja'*).<sup>31</sup> Any imbalance between these two will lead to hopelessness and depression.<sup>32,33</sup> As noted in the findings, fear and hopelessness can be a result of having committed a perceived sinful act in the past. Islamic cognitive restructuring is based on Islamic beliefs e.g. repentance (*tawbah*) will expiate previous misdeeds and the belief in an ultimate relief after hardship (Quran 94: 5-6), can be employed to substitute guilt and hopeless thoughts.<sup>28</sup> Apart from integrating religio-spiritual dimension in therapy, there is a role that can be played by Muslim chaplain which based on author's clinical experience, still needs empowerment in Malaysia especially in the field of psychiatry.

One of the limitations of this study was that, there was no obtainable representative from Muslim Chinese to be interviewed as a patient. This might reduce the variability of the outcomes.

## CONCLUSION

Islam is embedded in the lives of many Muslims. Desecration of patients' spiritual needs may lead to negative outcome. The integration of spirituality and religion into the treatment of psychiatry is warranted but needs multidisciplinary collaboration from psychiatrists, nurses and chaplains who are sensitive and well-informed about patients' spiritual beliefs and needs.

The different findings between Islam, Christian and secular societies, reiterates the need for more research to be done among Muslim communities as spirituality/religiosity is a realm that is beyond unanimity. More studies are needed to demonstrate its scientific basis and to design an effective psycho-spiritual treatment modality so that the 'holistic' or 'bio-psychosocial-spiritual' treatment can be integrated by health care professionals to those in needs.

## Conflict of Interest

None declared

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