

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/283153568>

Free will perceptions and religion in patients with schizophrenia and their caregivers

Article in *Psychiatry Research Journal* · March 2012

CITATIONS

2

READS

106

4 authors:



Amy Weisman

University of Miami

71 PUBLICATIONS 1,132 CITATIONS

SEE PROFILE



Michael George Mejia

University of Kentucky

5 PUBLICATIONS 4 CITATIONS

SEE PROFILE



Kayla Gurak Thayer

University of Miami

13 PUBLICATIONS 25 CITATIONS

SEE PROFILE



Stephen Sapp

University of Miami

14 PUBLICATIONS 14 CITATIONS

SEE PROFILE

Some of the authors of this publication are also working on these related projects:



Attitudes toward Telehealth Survivorship Services among Individuals with Early-Stage Lung Cancer [View project](#)

FREE WILL PERCEPTIONS AND RELIGION IN PATIENTS WITH SCHIZOPHRENIA AND THEIR CAREGIVERS

Amy Weisman de Mamani, Michael Mejia,
Kayla Gurak and Stephen Sapp*

University of Miami

ABSTRACT

This manuscript explores how free will perceptions relate to religious beliefs and values and psychological functioning in patients with schizophrenia and their family members. The paper begins with a discussion of what free will means and where laypeople stand on the question of its existence (from the literature, it appears that the overwhelming majority of the general public do subscribe to a free will perspective). Next we review psychological research on free will. Studies suggest that belief in free will has benefits to both the individual (e.g., greater self-esteem) and to society (e.g., lower rates of aggression and crime). Next we discuss components of free will and our premise that free will subsumes the following constructs: locus of control, self-efficacy, motivation, and meaning-making coping. We then turn to an overview of how free will and religion interact. We contend that a free will perspective is compatible with most Western religious views because most of these religions are founded on the premise that free will exists. The second section of the paper addresses how free will relates to functioning in patients with schizophrenia and their caregivers. Two case examples are presented. Drawing from the literature, our own empirical studies, and the numerous patients and caregivers we have treated as part of our Schizophrenia Family Project, we propose the following hypotheses: For both patients and their relatives, those who endorse greater free will beliefs (toward self) will experience greater psychological well-being and greater quality of life. For patients, we also propose that the severity of their psychiatric symptoms will be less severe. Finally, this paper will examine how free will perceptions may relate to religious beliefs and values to impact mental health in schizophrenia patients and their relatives. Implications from this review suggest that mental health practitioners in contact with individuals with schizophrenia and their caregivers may better serve them by fostering the notion that, despite the illness, they are still free to assume an active, autonomous role in the course of their lives. More empirical research in this area is clearly needed.

*Correspondence: Amy Weisman de Mamani, Ph.D. Associate Professor, Dept of Psychology, University of Miami, 5665 Ponce de Leon Blvd. Coral Gables, FL 33146. Phone: (305)284-3477. Fax: (305)284-3402 E-mail: aweisman@miami.edu

INTRODUCTION

“...Forces beyond your control can take away everything you possess except for one thing, your freedom to choose how you will respond to the situation. You cannot control what happens to you in life, but you can *always* control what you will feel and do about what happens to you.”

(Kushner, 2006, foreword to Viktor Frankl's *Man's Search for Meaning*, p. X)

This quotation (written by Harold Kushner) poignantly summarizes Viktor Frankl's philosophy. In his renowned book, *Man's Search for Meaning*, Frankl notes that concentration camp workers who were able to retain a sense of dignity and maintain a purpose for which to live were likely to survive longer and keep apathy at bay. Many were highly devout Jews who found in their religion a purpose for living and resisting their oppressors. Frankl's viewpoint is clear: He believes that people cannot always control their circumstances but they can control how they view or react to them. Philosophers, psychologists, and other scholars can be found with opinions that both support and refute the claim that humans can control their fate in this way. Although some attention will be paid to the validity of this viewpoint, this paper will focus primarily on the advantages (and in some cases, potential consequences) of holding the perspective that one always retains the freedom to choose how to respond to events, particularly in the face of adversity. The interplay among free will, religion, and related constructs (e.g., locus of control, self-efficacy) will also be addressed.

The “adversity” under scrutiny in this article is a serious mental disorder known as schizophrenia. Specifically we will examine how free will perceptions may relate to psychiatric symptoms and the course of illness in patients with the disorder. We will also examine the impact of free will beliefs on caregivers of individuals afflicted with schizophrenia. Two clinical case examples from our own research will be provided. The last section of the paper addresses the complexity of addressing free will in self versus other and briefly describes where our research is heading to disentangle this issue.

What Is Free Will and Do Laypeople Believe in It?

Free will has been defined in many ways but it is generally considered to be the ability of agents to make choices that are free from constraints. Baumeister, Crescioni, and Alquist (2011) describe it as a unique form of action control that came about to meet the increasing demands of human life, especially moral action and the pursuit of enlightened self-interest. There are multiple ways of thinking about free will, and when viewed from different perspectives, its meaning can change dramatically (Howard, 1994). It is a multifaceted construct that in our view includes (but is not limited to) the following dimensions: locus of control, self-efficacy, meaning-making coping, and motivation.

It is important to point out that many psychologists and philosophers who assert that free will exists do not argue that it is absolute. That is, they believe that people have some say in who they are, how they respond to things, or what they do (Dweck & Molden, 2008). Proponents of free will emphasize the possibility that, in almost any given situation, a person can act or react in more than one manner. In his experiences in four concentration

camps, Viktor Frankl observed that great variability existed in the manner in which prisoners reacted to the stress of internment. Some became completely detached, helpless, and hopeless, just waiting to die. Others became “animals,” treating fellow prisoners even worse than the guards did. On the other hand, there was a small, albeit noteworthy, number of men who, despite all of the excruciating physical and mental controls that were placed on prisoners, managed to act with kindness, humor, and in solidarity with other prisoners. Frankl notes that the minority who were able to remain positive and optimistic were those who used the tragedy as an opportunity to reflect on their lives, find meaning in the experience, and maintain hope and dignity regardless of the real possibilities. The following quotation pertaining to these observations sums up Frankl’s free will perspective: “...in the final analysis it becomes clear that the sort of person the prisoner became was the result of an inner decision, and not the result of camp influences alone. Fundamentally, therefore, any man can, even under such circumstances, decide what shall become of him—mentally and spiritually. He may retain his human dignity even in a concentration camp” (Frankl, p. 66).¹

Free will is often viewed as the antagonist of determinism. The deterministic position leaves no room for free human choice. From this perspective, everything that happens is the unavoidable product of prior causes (Baumeister, 2008). Psychologists tend to be divided on whether people have free will. Some believe that freedom of will exists because people make choices and can theoretically choose differently under the same circumstances. Others believe that psychology must explain all behavior in terms of causes. Consequently, if a behavior is caused then it is not truly or fully free (Baumeister & Bushman, 2008). Ultimately, the definition of free will and the validity of this view are philosophical issues. However, whether people believe they possess free will and the consequences of this belief (or lack of it) fall squarely within the purview of psychology. This topic will be addressed further below.

According to most contemporary scientists, belief in the notion of free will is widespread. For example, based on their research Baumeister, Crescioni, and Alquist (2011) offer evidence for the following four hypotheses:

1. Laypeople generally believe in free will.
2. Belief in free will has favorable social consequences, which include increases in socially and culturally desirable behavior.
3. Laypeople are able to differentiate free actions from less free actions reliably.
4. Actions that are viewed to be free are thought to emerge from the following inner processes: planning, initiative, self-control, and rational choice.

The idea that ordinary people believe in free will is not new. Philosophers such as Arthur Schopenhauer (1883) have long espoused the view that belief in free will is extensive. For example, in *The World as Will and Idea* Schopenhauer wrote, “Everyone believes himself a

¹Stemming from this philosophy, Frankl developed logotherapy, an existential analysis based on the premise that a person’s primary motivational force is to find meaning. Logotherapy has the following three primary tenets: 1) life has meaning under all circumstances, even the most miserable; 2) one’s main motivation for living is to find meaning in life; and perhaps most important 3) people have freedom to find meaning in what they do, what they experience, or at least in the stand they take when faced with a situation of unchangeable suffering.

priori to be perfectly free, even in his individual actions, and thinks that at every moment he can commence another manner of life (p. 147).”²

Most of the research to date that has examined people’s free will beliefs has been conducted in Western cultures. However, a recent study by Sarkissian, Chatterjee, de Brigard, Knobe, Nichols, and Sirker (2010) examined intuitions about free will and moral responsibility in college students from four countries: the United States, India, China, and Colombia. Interestingly, they found a striking degree of cultural convergence in line with the views presented by Baumeister, Crescioni, and Alquist (2011) and their predecessors. In other words, in all four cultures the majority of participants espoused the view that free will exists. As research outlined throughout this manuscript will support, many mental health benefits may result from espousing this view.

The Study of Free Will in Psychology

The topic of “free will” has received the most attention in the disciplines of religion and philosophy (Stroessner & Green, 1990). This is, no doubt, in part because the most debated question regarding free will, namely, whether people have it, does not lend itself readily to the empirical methods required in disciplines such as psychology. On the other hand, beliefs and perceptions about free will can be studied empirically. Yet psychological explanations rarely mention free will as a factor (Baer, Kaufman, & Baumeister, 2008), and the topic has been empirically investigated in only a handful of psychological studies.

Despite the scarcity of empirical research directly examining free will beliefs, the findings are compelling. For example, studies have shown that inducing disbelief in free will tends to increase aggressive behavior and reduce willingness to help others (see Baumeister et al., 2009) and to increase dishonest behavior such as cheating on a test (Vohs & Schooler, 2008). Rakos, Laurene, Skala, and Slane (2008) found that a strong sense of free will was associated with higher self-esteem in both adolescents and adults. The authors argue that, as humans evolved, people who believed they possessed free will were better at manipulating their environment in choice situations. In turn, they were better at decision making and problem solving and had more self-restraint, all of which are characteristics associated with improved psychological and physical health. Thus it appears that free will perceptions have important behavioral, emotional, and societal ramifications and are therefore highly worthy of further scientific research in psychology.

FREE WILL AND UNDERLYING CONSTRUCTS

Notions of free will and determinism are closely linked to and include related psychological constructs such as self-efficacy and locus of control and more general

²It is important to point out, however, as the rest of the quotation implies, that Schopenhauer himself was a determinist: “...But a posteriori, through experience, he finds to his astonishment that he is not free, but subjected to necessity, that in spite of all his resolutions and reflections he does not change his conduct, and that from the beginning of his life to the end of it, he must carry out the very character which he himself condemns.” [An ellipsis is not necessary at the beginning and end of quotations because it is assumed something precedes and follows. I have left them at the beginning here, though, to indicate the “attachment” to the part in the text.]

psychological factors such as moral and effortful choice, motivation, and meaning-making coping. Following Baumeister, Bauer, and Lloyd (2010), we view free will as a higher order process that subsumes and synergizes many of these related constructs. All of these factors share an underlying commonality pertaining to the question of whether people have the capacity to exert control over their environment and bring about desired emotional and behavioral outcomes.

An internal locus of control and a confident self-efficacy are two essential elements of free will (Waller, 2004). The construct of Locus of Control (Rotter, 1966) refers to the perception that a person holds regarding which factors control positive and negative reinforcements for their actions and whether these factors are internal or external to the person. A determinist would likely hold a view that favors an external locus of control, believing that people do not have control over the outcome of their actions but rather that they are the result of luck, chance, fate, or powerful others. Free will proponents, however, generally hold a position favoring an internal locus of control, characterized by the perception that outcomes are a result of their own actions or other internal forces (e.g., thoughts). These relationships may have implications for a person's understanding of moral responsibility, another aspect of free will perceptions. If people hold the view that they and/or others are capable of acting in a responsible or correct manner, then they are also likely to believe that they and others ought to behave in the approved manner. In this way free will subsumes both locus of control and moral and effortful choice.

In addition to an internal locus of control, free will supporters also believe that they are generally able to exercise control effectively. In other words, free will requires self-efficacy (Waller, 2004). The construct of self-efficacy was introduced by Albert Bandura (1977) and refers to perceiving a sense of competence to carry out a task successfully and achieve a desired result. According to this theory, self-efficacy beliefs can influence motivation in that the greater people's belief that they will be able to carry out certain behaviors efficaciously, the more likely they are to undertake challenging tasks to begin with. Thus free will subsumes self-efficacy beliefs and motivation as well.

A free will perspective implies perceived control not only over behaviors but also over thoughts and emotions. Free will proponents generally believe they are in control of their emotional reactions to events and are able to construe their emotions adaptively. To achieve this aim, free will believers tend to be adept at a meaning-making coping style that allows them to reframe suffering and other potential adversities in a manner that is beneficial, or at the very least, tolerable. In fact, we believe that it is the ability to reconstrue events adaptively and take control of one's emotions that makes a free will perspective particularly adaptive.

Free Will and Religion

Free will and religion have much in common, with both constructs evoking questions regarding human choice, willpower, and self-control. The notion of free will whereby people are seen as authors of their own actions is at the heart of the "Western" (or more accurately, Abrahamic) religions of Judaism, Christianity, and Islam. For example, these religions assume that people can freely choose to perform sinful or virtuous acts (Baumeister, Masicampo, & DeWall, 2009), though reconciling such freedom with God's omnipotence is a particularly vexing theological challenge for these religions. Baumeister et al. (2010) note that

regardless of whether free will exists, belief in it appears to benefit society. Religion, by way of promoting this belief, can improve functioning within a civilization and therefore benefit the society itself.

There is strong empirical evidence that religion is associated with both mental and physical health. For example, studies have linked greater interest in religion and religious practices with better self-esteem, greater personal adjustment, less alcohol and drug abuse, and less sexual permissiveness and suicide (Pargament, et al., 1988; Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Waite, Hawks, & Gast, 2000). McCullough et al. (2000) conducted a comprehensive meta-analysis and found that greater religious involvement was associated with much lower odds of dying prematurely.

In this paper we follow Baumeister, Baer, and Lloyd (2010) by proposing that religion may benefit individuals and society in part by supporting belief in free will. Specifically, most organized religions encourage followers to believe that they can choose to resolve dilemmas by controlling selfish impulses and thoughts that might cause harm to themselves or others. Many religions encourage followers to resist immediate temptations in favor of more significant long-term goals to bolster inner restraints and to curb aggressive inclinations, and to replace these with prosocial behaviors that appear to benefit most members of society.

Applying the Study of Free Will to Schizophrenia Patients and Their Caregivers

Schizophrenia Patients

Schizophrenia is generally considered to be one of the most severe forms of mental illness. It is marked by general disorganization in thinking, behaving, and perceiving. People who have this illness are often unable to think logically, perceive what is happening around them accurately, and, unfortunately for many, hold a job and live a normal everyday life (Beidel, Bulik, & Stanley, 2010). In many respects, the onset of the disorder is often associated with an afflicted person's loss of sense of control over his or her destiny. Family members often try to inflict constraints and limits on patients' daily activities and behaviors. Psychiatrists frequently impose medications. Mental health practitioners oblige or encourage psychotherapy and other sorts of behavioral controls. Even the symptoms themselves seem to belie a free will perspective. For example, delusions of influence are frequent in patients with schizophrenia. Common themes include beliefs that thoughts are being removed from one's head, that government or alien forces are stealing one's thoughts, or that one's private thoughts are being transmitted over the television or radio (Beidel, Bulik, & Stanley, 2010). Patients with schizophrenia often have great difficulty discriminating between self- and other-generated information and actions and often attribute self-generated information to others. In other words, many patients believe they are not free to control something as private and fundamental as their own thoughts. Interestingly, in a qualitative analysis of recovery from schizophrenia, Davidson (2003) observed that people with schizophrenia often identify reestablishing their sense of agency as a key component in recovery. It is worth quoting a summary of his observations that are based on several in-depth interviews aimed at capturing patients' own phenomenological experiences of their illness. Davidson eloquently writes:

Being unable to retain a sense of oneself as the source of the direction of one's own awareness may thus deprive the person with schizophrenia of the most fundamental sense of ownership of his or her own experiences. Without this basic self-awareness, people may then lose their secondary sense of themselves as agents active in and affected by the world. The impact of voices and cognitive disruptions in this way reverberates throughout the person's experience of self leading to the constitution of a sense of personal identity built more on feelings of being controlled by and vulnerable to external influences than of being the agent of one's own thoughts, perceptions, and feelings as well as actions (p. 141).

As the preceding passage illustrates, helping patients capture or recapture a free will perspective may be useful in rebuilding their confidence, happiness, and health after schizophrenia strikes. We now turn to a clinical case example of a patient that we will call Marcia³ who, one could argue, had overwhelming and largely irreparable consequences as the direct result of her illness. Her worldview, however, which is very much in line with a free will perspective, appears to have allowed her to live a meaningful and happy life.

Marcia, a devout Christian, is a woman in her late 70's suffering from schizophrenia. She first came into contact with our research laboratory approximately five years ago and has been steadily involved in different aspects of our schizophrenia intervention research. Members of our research team know her very well. Marcia experienced her first bout with serious mental illness in her late 30's. Prior to this, she was happily married with three children and a satisfying and thriving career. During this bout she became highly paranoid and suspicious of everyone, including her loved ones. She also became highly disorganized, complained of hearing voices, and became exceedingly anxious to the point of being largely unable to leave the house. Less than a year following the first psychotic episode, Marcia's husband, fearing for his and their children's safety, filed for divorce and moved to a new state, taking their young children with him.

Shortly thereafter, Marcia lost her job and was never again able to resume work. Following the psychotic break (and subsequent divorce and job loss) one of Marcia's siblings stepped in and took on a primary role as her caregiver and guardian, accompanying Marcia to all psychiatric appointments and treatments and overseeing most of her daily activities for approximately forty years. Since her psychotic break, Marcia has had almost no contact with her children (aside from a few isolated phone conversations and a handful of visits). Sadly, over a year ago Marcia's sibling (who was also her caregiver and closest friend and confidant) died after a long bout with cancer.

Given the circumstances of her life, another person in Marcia's shoes might have become dejected and felt bitter after losing (and never managing to regain fully) the things that the majority of people report as the most meaningful and important to their wellbeing (e.g., children, marriage, and a career).⁴ However, from the beginning (as much as we would like to take credit for a change in her outlook), what was most striking about Marcia was her pervasively optimistic stance toward life and an uncanny ability to find the good in every situation, even those that most people would experience as devastating.

³Pseudonyms are used for both clinical case examples provided in this manuscript and a few demographic facts have been altered to protect participants' identities.

⁴Research corroborates that these factors (marriage, family, meaningful work) are among those most closely related to happiness (Myers, 1993).

To cite a few representative examples, following the death of her brother, Marcia displayed deep and appropriate grief over her loss. However, within a few short weeks she was also able to transform her grief and energies into a profound sense of gratitude. This went far beyond feeling appreciative for having had such a kind and wonderful brother and also went past feeling indebted to him for the care that he had given her. Instead of viewing his illness and death as another major life blow, she focused on what the situation had to offer her, namely, the opportunity to reverse roles and tend to her brother's physical and emotional needs during his final hours. In other words, she reported and continues to report comfort in knowing that she was able to reciprocate the extensive care that he had provided to her over the years. This opportunity appears to have given her a deep sense of satisfaction and purpose and helped her to find a greater meaning in his illness and in his death. Marcia also expressed gratitude that her brother had gone first and therefore did not have to deal with the pain of her eventual death.

Marcia was similarly able to construe the loss of her children and her failed marriage in a productive manner. Although she does express occasional sadness and guilt over not having been a regular part of her children's lives, she focuses much more of her energy on feelings of thankfulness that the father of her children had the good sense to take them away when she was psychotic. She also reports feeling grateful that he was in a position to provide them the kind of loving and consistent care that she herself, during the acute stage of her illness, could not.

It is important to convey that Marcia's outlook goes well beyond life's great challenges. In her day-to-day living she is able to address her setbacks head-on and also provide care, support, and a sense of meaning to the difficulties of others in her therapy group. Though she is in late life, she continues to reinvent herself, taking on and even embracing new responsibilities and activities that she once believed were beyond her capacities (e.g., buying a new house and living alone). She continually creates new friendships and most importantly remains vocal and adamant in her stance that life is beautiful and worth living at any age or under any circumstance. Marcia recently declared that this year she had the "best holiday season since her psychotic break." She explained that for so many years she had just been managing her symptoms and trying to offset the chances of another episode, but that now she is finally able to experience joy again. She honored the holidays in small but meaningful ways, by buying herself eggnog and fruit cake and listening to holiday music in her apartment. She is taking control of her illness with more confidence each and every year. Marcia also recently joined Weight Watchers®. This was a major and very carefully planned step for her because over the past forty years all of her social activities, save family functions, have been defined by her illness. When Marcia first told her therapy group that she had joined, she said, "It's time for me to get control of this" ("this" being her weight). Marcia reported wanting to work on gaining self-esteem and feeling self-control in areas other than managing her symptoms. She continues to have minor psychiatric symptoms (though most are well controlled on medication and in recent years have been more in the realm of anxiety than psychosis). However, the manner in which she chooses to cope with her illness and all of her life's setbacks has allowed her to lead a life that she views as worthwhile and happy, while several of our other patients in similar (or in many cases even more favorable circumstances in an objective sense) have not thrived nearly as well.

Schizophrenia Caregivers

Schizophrenia is an incapacitating mental illness that takes its toll not only on the person who suffers from it but on family members as well, resulting in high levels of caregiver distress and burden. Family members report experiencing an array of difficulties, including grief over losses experienced by the patient, family conflict caused by the illness, financial strain, restricted leisure and social activities, feelings of stigma, and shock over witnessing bizarre symptoms in a loved one (Friedman-Yakoobian, Weisman de Mamani, & Mueser, 2009).

Although most family members report experiencing disruption in their lives as a result of the illness, we once again see remarkable variability in family members' emotional and behavioral responses to the disorder. We turn now to an example of one caregiver who we believe exemplifies what a free will perspective can do.

Miriam is the mother of Max,³ a 30-year-old male with schizophrenia. Max is an attractive, personable young man of superior intelligence. Miriam and her family had exceptionally high hopes for Max both professionally and personally. Max was a college student during his first psychotic break. However, the symptoms of his illness were severe enough to prevent him from completing college, dating, or holding down a professional job (he has been able to earn money from some manual labor and other blue-collar jobs occasionally). Initially, Miriam was devastated that despite Max's intellectual and other gifts, he would not be able to reach his full potential. However, instead of turning inward in despair, Miriam and Max took control of the illness. A primary mission in Miriam's life became "not to let the illness control Max or me." Miriam sought family and group therapy, joined family member support groups, and became actively involved in political organizations that champion the rights of mentally ill patients. She also utilized services around her Jewish faith to help her cope with the illness. In addition, she learned as much as she could about the illness and ways of interacting with Max that have also helped him to thrive. As part of her family treatment in our project, she became fascinated by a body of work called expressed emotion (frequently referred to as EE; see Weisman de Mamani, Dunham, Aldebot, Tuchman, & Wasserman, 2009, for a review). This area of research shows that patients with loving and supportive relatives fare better and keep symptoms at bay more effectively than those whose family members express high levels of hostile and critical attitudes toward them. Miriam embraced this knowledge, and we have been struck by how competent she became at responding to Max's symptoms in a calm and patient manner, where previously she had reacted with anger and frustration. She held great faith that she could change, and in essence she did. As tension in the household subsided, so did the severity of Max's symptoms.

Over the years, both Miriam and Max have been able to find great meaning in his illness. Max, a talented artist, has used his symptoms as inspiration for his music, photography, and art (which he frequently performs and displays live). Miriam would still like to see Max "conquer" his illness and she continues to dedicate her life to finding both better treatments for schizophrenia and a cure. However, she has also come to the realization that Max would never have become the wonderfully complex person that he is today without having had schizophrenia. For instance, both Miriam and Max strongly believe that Max never would have realized his full artistic potential without the illness. This is significant in that Max's art represents one of his greatest sources of pleasure and pride (and is also a source of pride and joy for the rest of the family). In essence, for many caregivers the illness becomes nothing more than an encumbrance. For Miriam, however, finding a way to construe

it and react to it helped her and her son feel stronger about themselves. In fact, in many ways they report feeling stronger as individuals and more cohesive as a family than prior to Max's first psychotic break.

Religion and Schizophrenia/Severe Mental Illness

Much like the research above demonstrating benefits of belief in free will in normative populations, the preponderance of evidence in schizophrenia, though complex, generally indicates that being more religious has mental health benefits for patients and their caregivers (see Weisman de Mamani, Tuchman, & Duarte, 2010, for a review). For example, in a sample of psychiatric inpatients, Pieper (2004) found that religion had a positive impact on the manner in which patients dealt with mental health problems. Greater general religiousness and greater religious coping were both associated with greater existential well-being. In a study of caregivers of patients with mental illness, greater religiosity was correlated with less depression and better self-esteem and self-care (Murray-Swank, et al., 2006). In another study, religiosity was found to be inversely related to symptoms of depression among caregivers (Magana, Ramirez, Hernandez, & Cortez, 2007).

On the other hand, using the Moral Religious Emphasis subscale of the Family Environment Scale (Moos & Moos, 1981), Weisman, Rosales, Kymalainen, and Armesto (2005) found no relationship with general emotional distress in schizophrenia caregivers. The authors note that the absence of a correlation may be due to the measure used in the study, which is designed to assess institutional religiosity (e.g., going to church) as opposed to more intrinsic elements (e.g., holding religion as a master framework for living).

This explanation is supported by a meta-analysis of 34 studies which found that, overall, religiosity appears to be positively correlated with mental health (Hackney & Sanders, 2003). However, measures of institutional religiosity were shown to have the weakest predictive ability in this context. Hackney and Sanders (2003) concluded that the contradictory findings observed in previous research on religiosity and mental health can be explained by differences in operationalization.

The importance of having clear operational definitions also appears in research examining religious meaning-making coping styles, which addresses control-related beliefs about one's relationship with God.

For example, in a sample of patients with serious mental illness, Phillips and Stein (2007) examined the following three religious meaning-making coping styles: benevolent religious reappraisals (attempts to redefine a stressor as having religious benefits), punishing God reappraisals (redefining the stressor as a punishment from God), and reappraisals of God's power (redefining God's ability to influence stressful events such as viewing God as incapable of altering a stressful situation).

They found that benevolent religious reappraisals were associated with more positive mental health, whereas reappraisals of God's power and punishing God reappraisals were associated with poorer mental health. This line of research suggests, and many researchers concur (e.g., Payne et al., 1991; Weisman et al., 2005), that it is more important to understand *how* a person is religious than *whether* a person is religious. Consequently, studies that examine religiosity as a construct should rely on varied and multi-dimensional methods of assessment.

In our experience, religious patients and caregivers who view God or another higher power as an aid to assist them in selecting the best course of action when other alternatives are available or to accept adversity with dignity and calm when other alternatives are not available fare far better than those who passively turn to God or religion for answers.⁵ We recently conducted a pilot study that assessed the connection between attributions of God control and psychological distress (using the Depression, Anxiety, Stress Scale; Lovibond and Lovibond, 1995) in 81 family members of individuals with schizophrenia (Tuchman, Mejia, & Weisman de Mamani, 2010). Those who agreed with the statement “God controls most things that happen to us, including mental illness” reported greater distress than those who disagreed. In other words, the perception that God controls a loved one’s illness (i.e., that free will is limited) may cause distress because it suggests that even with serious planning, initiative, and wise choices, patients and their relatives do not have the power to control mental illness (this perception may have a detrimental impact on mental health similar to that of holding punishing God reappraisals observed by Phillips and Stein [2007] and discussed in the previous paragraph). Because freedom and choice are deeply woven into the fabric of human relations (Baumeister, 2008) and Western societies place a high premium on them, it is not surprising that mental health may deteriorate when perceptions of free choice and control are challenged or lacking.

In short, religion may be useful to individuals in coping with schizophrenia partially because it supports both the exercise of and the belief in free will (Baumeister, Bauer, & Lloyd, 2010).

Self versus Other Free Will Perspective in Schizophrenia Caregivers

A potential disadvantage to a robust free will perspective may be that unfair blame is placed upon others (and perhaps oneself) when things go wrong. Some of our own data and those of colleagues suggest that there may be circumstances for which increasing free will views in caregivers could be associated with detrimental attitudes toward patients. For example, the first author of this article and colleagues (e.g., Weisman et al., 1993, 1997, 1998) and others (Brewin, MacCarthy, Duda, & Vaughn, 1991) offer data that suggest that family members who perceive patients with schizophrenia as having greater control over their illness and the associated symptoms are more likely to be blaming, hostile, and critical toward them. As noted earlier, high EE attitudes in relatives are associated with a poor course of illness for patients (Weisman de Mamani et al., 2009). Breitborde, López, and Nuechterlein (2009) also reported finding that high-EE caregivers perceive the expression of symptoms as stemming from their ill relative’s agency more frequently than did low-EE caregivers. This study is well-written and offers interesting insights. However, it is important to note that “agency” was measured by only one item: “How did (ill relative) come to contact the hospital this most recent time?” This item was confounded with EE in that it was derived from the opening passage of the Camberwell Family Interview (the same interview used to assess EE) and the agency coder was not blind to EE status. Furthermore, from the description of the open-ended rating system described in the paper, it is unclear how the

⁵In fact, this message is strongly espoused by theologian Reinhold Niebuhr’s famous Serenity Prayer, perhaps best known through its association with Alcoholics Anonymous: “God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.”

construct of “agency” is different from the construct of “control” used in prior studies (e.g., Brewin, MacCarthy, Duda, & Vaughn, 1991; Weisman et al., 1993, 1997, 1998).

In this paper we have proposed that caregivers who hold a greater free will view are also likely to be happier and healthier. As illustrated above in the case of Miriam, we believe this view may translate into behaviors that also benefit patients. On the other hand, research described in the preceding paragraph complicates this issue and raises the question of whether the adaptive benefit of free will perceptions may vary depending on whether the agent is self or other. This topic is worthy of additional investigation.⁶

One aim of our future research will be to examine directly how free will relates to agency (self versus other) in caregivers’ reactions toward symptoms in a loved one. An existing scale by Rakos, Laurene, Skala, and Slane (2008) includes items that may serve as a useful tool in evaluating this interesting question. For example, this scale contains two subscales: beliefs about oneself (“I am in charge of my actions even when my life’s circumstances are difficult”) and beliefs about people in general (“Life experiences cannot eliminate a person’s free will.”) Our research team is also currently developing a “Free Will Beliefs in Schizophrenia Scale.” This instrument will be combined with existing scales to examine more explicitly patients’ and caregivers’ free will beliefs in direct response to the illness. More research is clearly needed to tease apart the self versus other distinction in free will beliefs toward schizophrenia. We hope that our new scale in conjunction with existing measures will allow us to speak more directly to these interesting questions.

CONCLUSION

In summary, this paper reviewed the literature on free will perceptions and religion in patients with schizophrenia and their caregivers. Stemming from the studies reviewed above, we conjecture that both patients and their relatives who endorse greater free will beliefs (toward self) will experience lower levels of depression and anxiety and greater quality of life. Extrapolating from the research above, we also theorize that patients with schizophrenia who endorse greater free will beliefs (toward self) will display less severe psychiatric symptoms. We hope that we have conveyed our belief that instilling a free will view in patients with schizophrenia and their caregivers would likely help them to manage and cope with the illness more effectively. More research is needed to validate these claims empirically.

In closing, we turn once more to Frankl (2006):

“An incurably psychotic individual may lose his usefulness but yet retain the dignity of a human being. This is my psychiatric credo. Without it I should not think it worthwhile to be a psychiatrist” (p.133).

⁶Although most people subscribe to a free will perspective, people are generally able to distinguish free from unfree situations. For example, the United States legal system is based on the view that free will exists. However, the insanity defense, which views a defendant as incapable of distinguishing between right and wrong, is an exception. Thus even caregivers who are avid free will proponents may be able to judge culpability accurately when reacting to bonafide symptoms of schizophrenia in their loved one (particularly those who have been properly educated about the illness and its symptoms).

“.... a seemingly hopeless madman has the potential to transcend evil or insanity by making responsible choices” (p. 162).

REFERENCES

- Baer, J., Kaufman, J. C., & Baumeister R. (Eds.) (2008). *Are we free? Psychology and free will*. New York, NY: Oxford University Press. [excerpt from jacket]
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*, 191-215.
- Baumeister, R. F. (2008). Free will in scientific psychology. *Perspectives on Psychological Science*, *3*(1), 14-19.
- Baumeister, R. F., Bauer, I. M., & Lloyd, L.A. (2010). Choice, free will, and religion. *Psychology of Religion and Spirituality*, *2*, 67-82.
- Baumeister, R. F. & Bushman, B. J. (2008) *Social Psychology and human nature* (p. 126). Belmont: Thomas Wadsworth.
- Baumesiter, R., Crescioni, A. W. & Alquist, J. L. (2011). Free will as advanced action control for human social life and culture. *Neuroethics*, *4*, 1-11.
- Baumeister, R. F., Masicampo, E. J., & Dwall, C. N. (2009). Prosocial benefits of feeling free: Disbelief in free will increases aggression and reduces helpfulness. *Personality and Social Psychology Bulletin*, *35*, 260-268.
- Beidel, D. C., Bulik, C. M., & Stanley, M. A. (2010). *Abnormal Psychology*. Boston: Prentice Hall.
- Blaire, R. J. (2007). Aggression, psychopathy and free will from a cognitive neuroscience perspective. *Behavioral Sciences and the Law*, *25*, 321-331.
- Breitborde, N. J. K., Lopez, S. R., & Nuechterlein, K. H. (2009). Expressed emotion, human agency, and schizophrenia: Toward a new model for the EE-relapse association. *Culture, Medicine and Psychiatry*, *33*, 41-60.
- Brewin, C. R., MacCarthy, B., Duda, K., & Vaughn, C. E. (1991). Attribution and expressed emotion in the relatives of patients with schizophrenia. *Journal of Abnormal Psychology*, *100*, 546-554.
- Davidson, L. (2003). *Living Outside Mental Illness: Qualitative Studies of Recovery from schizophrenia*. New York, NY: University Press.
- Dweck, C. S. & Molden, D. C. (2008). Self theories: The construction of free will (pp44-64). In J. Baer, J. C. Kaufman, and R. Baumeister R. (Eds.) *Are We Free? Psychology and Free Will*. New York, NY: Oxford University Press.
- Frankl, V. (2006). *Man's Search for Meaning*. Boston Beacon Press.
- Friedman-Yakoobian, M., Weisman de Mamani, A., & Meuser, K. (2009). Predictors of distress and hope in relatives of individuals with schizophrenia. *Israel Journal of Psychiatry*, *46*, 130-140.
- Gorsuch, R. L., & McPherson, S. E. (1989). Intrinsic/extrinsic measurement: I/E-revised and single-item scales. *Journal for the Scientific Study of Religion*, *28*, 348-354.
- Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion*, *42*(1), 43-55.
- Howard, G. S. (1994). Some varieties of free will worth practicing. *Journal of Theoretical and Philosophical Psychology*, *14*, 50-61.

- Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the Beck depression and anxiety inventories. *Behavior Research and Therapy*, 33, 335-342.
- Magana, S. M., RamirezGarcia, J. I., Hernandez, M. G., & Cortez, R. (2007). Psychological distress among Latino family caregivers of adults with schizophrenia: The roles of burden and stigma. *Psychiatric Services*, 58, 378-384.
- McCullough, M. E., Hoyt, W. T., Larson, D. B., Koenig, H. G., & Thoresen, C. (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology*, 19, 211-222.
- Moos, R. H., & Moos, B. S. (1981) Family environment scale manual (2nded). Palo Alto, CA: Consulting Psychologist Press.
- Myers, D. (1993). *The Pursuit of Happiness: Discovering the Pathway to Fulfillment, Well-Being, and Enduring Personal Joy*. New York: First Avon Books.
- Murray-Swank, A. B., Lucksted, A., Medoff, D. R., Yang, Y., Wohlheiter, K., & Dixon, L. B. (2006). Religiosity, psychosocial adjustment, and subjective burden of persons who care for those with mental illness. *Psychiatric Services*, 57, 361-365.
- Pargament, K.I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion and Spirituality*, 27, 90-104.
- Pargament, K.I., Koenig, H.G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology*, 9, 713-730.
- Payne, I. R., Bergin, A. E., Bielema, K. A., & Jenkins, P. H. (1991). Review of religion and mental health: Prevention and the enhancement of psychosocial functioning. *Prevention in Human Services*, 9, 11-40.
- Phillips, R. E., & Stein, C. H. (2007). God's will, God's punishment, or God's limitations? Religious coping strategies reported by young adults living with serious mental illness. *Journal of Clinical Psychology*, 63, 529-540.
- Pieper, J. Z. (2004). Religious coping in highly religious psychiatric inpatients. *Mental Health, Religion and Culture*, 7, 349-363.
- Rakos, R. F., Laurene, K. R., Skala, S., & Slane, S. (2008). Belief in free will: Measurement and conceptualization innovations. *Behavioral and Social Issues*, 17, 20-39.
- Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs*, 80(609), 1-28.
- Sarkissian, H., Chatterjee, A., de Brigard, F., Knobe, J., Nichols, S., & Sirker, S. (2010). Is belief in free will a cultural universal? *Mind and Language*, 25, 346-358.
- Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy Scale. In: J. Weinman, S. Wright and M. Johnston (Eds.), *Measures in Health Psychology: A User's Portfolio. Causal and Control Beliefs* (pp.35-37). Windsor, UK: NFER-NELSON.
- Schopenhauer, A. (1883). Second Book *The World as Will- First Aspect*. In R. B. Haldane and J. Kemp (Trans.), *The World as Will and Idea* (Vol. 1, p. 147). London: Trubner.
- Stroessner, S. J., & Green, C. W. (1990). Effects of belief in free will or determinism on attitudes toward punishment and locus of control. *The Journal of Social Psychology*, 130, 789-799.

- Tuchman, N., Mejia, M. G., & Weisman de Mamani, A. (November 2010). God control attributions and psychological distress in relatives of patients with schizophrenia. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco.
- Vohs, K. D., & Schooler, J. W. (2008). The value of believing in free will: Encouraging a belief in determinism increases cheating. *Psychological Science*, 19(49), 49-54.
- Waite, P.J., Hawks, S.R., & Gast, J.A. (1999). The correlation between spiritual well-being and health behaviors. *American Journal of Health Promotion*, 13, 159-162.
- Waller, B. N. (2004). Neglected psychological elements of free will. *Philosophy, Psychiatry and Psychology*, 11, 111-118.
- Weisman de Mamani, A., Dunham, R., Aldebot, A., Tuchman, N., & Wasserman, S. (2009). Family-focused psychoeducational programs for minorities with serious mental illness. In S. Loue and M. Sajatovic (Eds.) *Determinants of Minority Mental Health and Wellness* (255-272). New York: Springer.
- Weisman de Mamani, A. G., Tuchman, N., & Duarte, E. A. (2010). Incorporating religion/spirituality into treatment for serious mental illness. *Cognitive and Behavioral Practice*, 17, 348-357
- Weisman, A., Nuechterlein, K. H., Goldstein, M. J., & Snyder, K. (1998, August). Expressed emotion, attributions, and schizophrenia symptom dimensions. *Journal of Abnormal Psychology*, 107, 355-359. Featured in the *Clinician's Research Digest: Briefings in Behavioral Science*.
- Weisman, A., Rosales, G., Kymalainen, J., & Armesto, J. (2005). Ethnicity, family cohesion, religiosity and general emotional distress in patients with schizophrenia and their relatives. *The Journal of Nervous and Mental Disease*, 193, 359-368.
- Weisman, A., & López, S. (1997). An attributional analysis of emotional reactions to schizophrenia in Mexican and Anglo cultures. *Journal of Applied Social Psychology*, 27, 224-245.
- Weisman, A. G., López, S. R., Karno, M., & Jenkins, J. (1993). An attributional analysis of expressed emotion in Mexican-American families with schizophrenia. *Journal of Abnormal Psychology*, 102, 601-606.

Reviewed by

David Myers – Hope College, P. O. Box 9000, Holland, MI 49422-9000

Phone 616.395.7730; WEB: www.davidmyers.org

Email myers@hope.edu