Psychiatria Danubina, 2017; Vol. 29, No. 3, pp 238-244 https://doi.org/10.24869/psyd.2017.238 *View point article*
© Medicinska naklada - Zagreb, Croatia

RESILIENCE, PSYCHIATRY AND RELIGION FROM PUBLIC AND GLOBAL MENTAL HEALTH PERSPECTIVE

Dialogue and Cooperation in the Search for Humanistic Self, Compassionate Society and Empathic Civilization

Miro Jakovljevic

University Hospital Centre Zagreb, Department of Psychiatry, Zagreb, Croatia

received: 20.4.2017; revised: 27.6.2017; accepted: 28.7.2017

SUMMARY

Psychiatry has increasingly devoted its attention to the role of religion and spirituality in mental health and illness. All religions offer explanations for meaning and purpose of life, involving rationales for the reality of human suffering and traumas related to natural disasters, war, civil violence, torture, etc. In many countries different religious organizations have funded and operated mental health services as well as supported better understanding, empathy and compassion among cultures. A rapprochement between psychiatry and religion has been predicated on their overlapping goals to promote individual and community resilience, growth, and well-being. Due to progress in post-secular dialogue, psychiatry, religion and spiritual disciplines have the historical opportunity to shape the future of individual, public and global mental health as well as building compassionate society and empathic civilization.

Key words: *public and global mental health – resiliency – psychiatry – religion - compassionate society - empathic civilization*

* * * * *

Introduction

Psychiatry and religion are fascinating and controversial fields that many people misunderstand. The both have many debatable and arguable aspects and varied history. The both have been connected with ideology and politics in various ways since distant times. Throughout the history psychiatry and religion made it difficult to communicate with each other without conflicts about how human beings should understand and define themselves, the nature and the world, as well as mental, moral and spiritual health... Psychiatry has often ignored spiritual and religious dimension in health and illness while religions were defining mental disorders as evil spirit possessions or the works of demons which penetrated body and mind of sinned individuals. It is important to note that transcultural psychiatry has always taken the spiritual and religious beliefs and practices as relevant factor in understanding both mental health and mental disorders. The confrontation and alienation that existed between psychiatry and religion during most of the 20th century has been overcoming. Increasing number of articles and books on religion, spirituality, psychiatry and mental health have been published (Galanter 2005, Loewenthal 2007, Huguelet & Koenig 2009, Griffith 2010, Jakovljevic et al. 2010). In postmodern and post-secular psychiatry of the 21st century religiosity has been considered as a normal personality trait, and religion as an important component of life and culture. According DSM-5 (APA 2013), religion is recognized as part of the cultural context of the illness and health experience. Assessing spirituality and religious beliefs has become a standard part of psychiatric history, so that even different protocols, e.g. HOPE (sources of Hope, Organized religion, Personal spirituality and practices, Effects on medical care and end-of-life issues) have been developed.

As social practices psychiatry and religion should be allies in promotion of the common good, public and global mental health. Discernment what is good, true, valuable, meaningful and decisive in our lives and our parallel worlds belongs to the domain of both religion and science including psychiatry. Dialogue and mutual understanding, and even cooperation between psychiatry and religions have become a matter of the great importance for promotion of public and global mental health. The aim of this paper is to address and support possible cooperation between psychiatry and religion in promotion of public and global mental health, research, patient care and education.

Resilience, Spirituality, Well-being, and Mental Health: Brief Explanation of the Important Concepts

Sound mind in sound body on sound society and sound religion

Resilience, spirituality, well-being, salutogenesis and positive mental health have become commonplace terms and are essential constructs in trans-disciplinary integrative psychiatry, positive psychiatry and psychology (see Jakovljevic 2012, Jeste et al. 2015). However, there is no general agreement on the definitions and relationships of these constructs. So, for the time being the use of these terms should always be accompanied by a brief explanation of their respective meanings and theoretical framework.

Resilience is complex, multidimensional and dynamic process, very important for understanding of salutogenesis and pathogenesis. In psychology, resilience refers to the ability to bounce back from a negative experience (stress, adversity, trauma, threats, tragic) with competent and adaptive functioning (Soutwick & Charney 2013). In medicine, resilience refers to one's capability to recover when having an illness or disease. Resilience may be defined as a collection of protective factors that mediate the relationship between a stressful event, e.g. disease, and positive outcomes. It is an indivisible part of mental health and health in general, well-being and quality of life. Resilience is considered as a dynamic and modifiable process, gradually developed through the life span, by the facing and overcoming of adversary events. Individuals may be resilient in one domain and not in others, or they may be resilient at one spell of time and not at other periods of their lives. Resilience enables individuals and communities not only to survive and adapt to challenge but also to be better off and to grow and thrive (post-traumatic growth) in addition to overcoming a specific adversary. *Psychological resilience* is an ability to bounce back from negative emotional experiences. It is a protective collection of thoughts, actions and behavior that can be developed and improved by everybody. Psychological resilience consists of intrapersonal (how an individual relates to their own thoughts, feelings and behaviors) and interpersonal (how an individual relates to others). According to hybrid model (Shin et al. 2009) resilience is related to 1.the one's positive attitude toward restoration (optimistic thinking, having faith in getting better), 2.the power to reconstruct (ability to re-integrate overcoming difficulty, confidence to overcome difficulties) and control one's adversary or disease (coping skills, ability to control relapse prevention and illness, practicing health plan well), and 3.positive mutual interaction with supportive resource (support from medical experts, from family members, friends and other people). Resilient individuals have lower risk of disorders, illness and disease, better immune functioning, speeder recovery, and higher productivity. Spirituality and religiosity may act as resilience resources to manage adversity (Reutter & Bigatti 2014). Placebo response may be an expression of psychological and spiritual resilience (Jakovljevic 2017b).

Spirituality can be defined as a quality of human beings who are concerned or preoccupied with higher meaning or purpose in life rather than with affairs of the material world (Slade 2011). It is a dimension of human experience related to the sacred, the transcendent, or to ultimate reality. It also relates to the inner essence of the self and the sense of harmonious interconnectedness with self, others, world and the Ultimate Other. Spirituality is a growth oriented, motivating and integrating force for physical, biological, psychological and social dimensions of human life and a potential source of strength and well-being. It may or may not be associated with a specific religion, but it is always related to the subjective experience of something sacred, transpersonal, transcendental and greater than self as well as to feelings of awe, reverence, and love. Transcendental, vitality, meaningfulness and connectedness are essential elements of a spiritual experience which can be understood in either secular or spiritual terms (Slade 2011). *Vitality* is ability or powerful force of an organism to maintain its organic existence. It includes a creative attitude, being spirited, open to new experiences, and growing through inner exploration or meditation. Health, energy and enthusiasm are secular terms, while soul, grace and sanctity are spiritual terms related to vitality. Spirituality is associated with emerging of *higher values and deeper understandings and meanings of life*, frequently connected with a sense of mystery and awe. Art, science and literature are secular terms, while faith, scriptures and revelation are spiritual terms related to meaningfulness. *Connectedness* refers to a feeling of union or harmony with another being or thing which includes connection with a living, dead or imagined person, a cultural, ethnic or political group, humanity, nature or universe. Family, lovers and nature are secular terms, while God, fellowship and church are spiritual terms related to connectedness. Spirituality can enhance resilience by promoting a sense of coherence, hope, transcendental meaning and purpose, and by social support within spiritual community. Spiritual resilience can be defined as ability to recognize a higher meaning and altruistic perspective, both during good and bad times. It is associated with a cluster of positive beliefs, values, and habits of mind.

Religion is one of the most distinctive human phenomena which can be source of individual and community growth, strength, social solidarity and resilience, but also source of personal strain, terrorism and inter-religious conflict (Abu-Raiya 2013). Religion is usually depicted as a particular institutionalized or personal system of beliefs and practices (worship) related to the divine (Encarta Concise English Dictionary 2001). These beliefs concern the existence, nature, and worship of God, a god, or gods, and divine involvement in the universe and human life. Pargament's definition (1997), "religion is a search for significance in ways related to the sacred" (cited according Abu-Raiya 2013) fits the best in our context. Religious pathways are complex and dynamic processes in which people take in search of whatever they hold significant, including the sacred itself (Abu-Raiya 2013). The search can include psychological ends, such as meaning and purpose of life and self-development, social ends, such as intimacy with others and justice in the world, and spiritual ends, such as closeness to God and living a moral and ethical life (Abu-Raiya 2013). All major religions provide great stories that deliver a meta-narrative how we should live the lives of service and offer moral guidance (see Bloom 2011).

Mental health according to the WHO (2014) "is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Promoting mental health enhances resilience, and vice versa, enhancing resilience promotes better mental health. While some use well-being as a proxy measure of resilience, others treat one concept as a component of the other, and yet another group views one concept as a prerequisite of the other. "Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity" (WHO 2009). Religion is relevant for better or worse in both mental health and illness, as an etiologic, therapeutic, or palliative agent (Levin 2010, Griffith 2010). James (1902/1936/1990) identified two types of religious expression: 1."the religion of the sick sole" characterized by psychic neuralgia, loathing, irritability, self-mistrust, self-despair, suspicion, anxiety, and fear; and 2."the religion of the healthy-minded soul" which is implicitly positive, hopeful, optimistic, kind and prone to happiness (according Levin 2010).

Well-being or wellness is a general term for the positive outcome or condition of an individual or group. It is frequently used as an indicator of resilience, particularly when referring to resilience as a process of overcoming difficulties, adversity, or trauma so well that functioning is even better than before. The WHO (2009) has defined well-being as the 'presence of positive mental health, but the reliable definition of mental health and well-being remains elusive. Well-being has both noun (being at home in the world) and verb (living in balance with the trials of life) senses (Pickering 2012). Well-being encompasses the capacity to 1.actively participate in work and recreation, 2.create meaningful relationships with others, 3.develop a sense of autonomy, 4.personal mastery and purpose in life, and 5.to experience positive emotions joy, contentment, happiness (see Hatch et al. 2012). According I. Prilleltensky and O. Prilleltensky (2012) well-being can be personal, relational, organizational and collective. *Signs of personal well-being* are self-determination, sense of control, self-efficacy, optimism, meaning and spirituality. S*igns of relational well*-being involve caring, respect for diversity, reciprocity, nurturance and compassion, support, collaboration and democratic decision-making processes. *Signs of organizational well-being* appear as art and practice of learning organization (see Senge 2006), respect for diversity, democratic participation, clarity of roles, engagement and learning opportunities. *Signs of collective well-being* include a fair and equitable allocation of bargaining powers, resources, and obligations in society, gender and race equality, universal access to high quality educational, health and recreational facilities, affordable housing, employment opportunities, access to nutritious foods at reasonable prices, safety, public transportation, a clean environment, and peace (Prilleltensky & Prilleltensky 2012). *Emotional well-being* refers to the experience of feeling of happiness and satisfaction, *psychological well-being* is defined as a meaningful life in which an individual realizes their own capacities, whereas *social well-being* is related to the feeling than an individual values and is valued by the society in which he or she lives (see Fledderus et al. 2010). *Spiritual well-being* is related to following and achievement of spiritual values and higher level of life satisfaction in sense that it does not depend on any materialistic conditions of reality (see Joshi & Kumari 2011). *Religious well-being* is related to "the feeling of having a personally meaningful, satisfying and fulfilling relation with God" (Joshi & Kumari 2011), or supreme beings or transcendental world.

Coping mechanisms/skills can be defined as behaviours that an individual employ in order to prevent or avoid adversity and its consequences (see Hatch et al. 2012). According to Aspinwall and Taylor (1977) there are three types of coping: 1.coping with stressful events (actions to reduce or minimize perceived harm or losses), 2.anticipatory coping (preparation for the stressful event with potential harm or losses), and 3.proactive coping (accumulation of resources and acquisition of skills for general preparation for possible stressors). Religion coping activities include praying, reading sacred scriptures and texts, practicing religious rituals and services, etc.

Salutogenesis (the latin salus – health; the Greek genesis – origin) is related to healing that is natural process seen in all forms of life. Although man does not possess phantastic healing capacity of reptiles and amphibias, he does show a wide variety of health restorative processes involving the cellular repair of genetic mutations, the elimination of infectious agents, and the destruction of incipient neoplasia by immune mechanisms (Kradin 2008). According to salutogenic model (Antonovsky 1987) the balance between coping mechanisms (generalized resistance resources) and generalized resource deficits determines whether stressful and adversary factors will be pathogenic, neutral, or salutogenic. Salutogenesis and placebo response is associated with resilience resources (see Jakovljevic 2017b).

Spirituality and religion may play an important role in individual and community resilience, quality of life, and public mental health promotion

"The health of nations is the wealth of nations"
William J. Durant

Religion has had significant effects on mental health directing and modeling social behavior, explanatory styles and world-views that promotes well-being at both individual and community level. According to Joshi & Kumari (2011) it "acts as a social support system,

reduces the sense of loss of control and helplessness, provide a cognitive framework that reduces suffering and enhances self-esteem, give the confidence that one, with the help of God, could influence the health condition, and creates a mindset that enables the patient to relax and allow body to heal itself". Public mental health, spiritual well-being and social well-being are very closely inter-related but also distinct issues with multi-directional relationship. Public mental health is an important component of the social well-being while social well-being supports individual and public mental health. Spirituality, well-being and resilience are useful concepts for public and global mental health promotion because they integrate behavior of people and their mental health at individual and community level. Spiritual thinking modes help in creating peace, harmony and order at individual as well at community level. A fundamental component of the success of any communities is their ability/capacity to collectively build resilience in the face of constant and unpredictable change and adversary. So, one can say that individual and community well-being is an outcome of resilience. Spirituality and religion play an important role for many people in their resilience, well-being and quality of life across the life span. Religion offers a response to the problem of human insufficiency and suffering in the time of adversity and crisis (Faigin & Pargament 2011). Spiritual resilience represents a cluster of positive beliefs, values, and habits of mind that can be learned, cultivated and reinforced through positive religious education and practice. There is no firmly determined (one fits all size) way to react optimally to any given challenge or adversary, but rather an optimal way of responding to specific circumstances. Spiritual and social resilience can be enhanced within communities, both informally (practicing empathy and compassion in every day life) and formally (religious teaching resilience skills, broadening definitions of "family" and friend on everyone in community, society and civilization).

The idea that faith may possess salutogenic capacity is as old as both religion and medicine itself. A large body of empirical research has demonstrated relation between religious involvement, religious motivation and religious coping on one side and somatic and mental health on the other side (see Abu-Raiya 2013). Salutary effects of faith and religion have been demonstrated with many dimensions of resilience, mental health and well-being, such as self-esteem and personal mastery, hope, optimism, purpose and meaning, anxiety, depression. Advances in measurement theory and research in psychology and psychiatry suggest that resilience, well-being, spirituality and religiosity can be investigated with relatively reliable degree of accuracy. Quite a number of studies have shown that resilience, well-being, spirituality and religiosity are associated with personal, health, job, family, and community benefits. Religious faith can be associated with healing by different mechanisms that are depicted as behavioral, interpersonal, cognitive, affective, and psychophysiological mechanisms (Levin 2009). The concept of healing is an important context for understanding spirituality in terms of resiliency. Faith can be healing by eliciting healthy behaviors that enhance resilience and facilitate salutogenesis through conditioning and regulating the neuroendocrine and neuroimmune systems (behavioral/conative mechanism). Faith can be healing by connecting one to groups of like-minded people who can offer tangible and emotional support and encouragement (interpersonal resilience and well-being). "Confiding in other, human or divine, and reinforcing reciprocal bonds of assistance among individuals, or with divine others, has both health-promoting and disease-preventive consequences for populations" (Levin 2009). Faith can heal by establishing a mental framework, the mode of thinking and explanatory narrative that affirms one's innate healing ability by making sense of and accommodating individuals to their specific experiences and their place in the world (cognitive resilience). Faith can heal by engendering soothing emotions that buffer or mitigate the harmful effects of stress (emotional resilience). The positive feelings elicited by positive faith-based thoughts, beliefs, and experiences, personal or communal, both may directly modulate various neurobiological and epigenetic parameters (Feder et al. 2009, Russo et al. 2012) indicative of pathophysiology (neurobiological resilience). Faith can give one a sense that there is a purpose in what is happening and can help find hope, solace and comfort (spiritual resilience in narrow sense). In fact, all these resilience mechanisms are psychophysiological, but here the terms are used in traditional way of their meaning and defining.

Religion may be both blessing and curse; it may heal, it may harm; it may be salutogenic and it may be pathogenic; it may be healthy-minded and it may be sick-minded (Griffith 2010). Healthy-minded (salutogenic) and sick (distorted or pathogenic) expressions of faith are quite distinct – in the objects of faith, in the expectations of such faith, and in the observed effects and outcomes in the lives of the faithful (Levin 2009). Salutogenic faith motivated by intrinsic religion is associated with empathy, compassion, creativity, open-mindedness, self-esteem, altruism and social responsibility. Healthy minded faith is the fuel that produces constructive social and cultural transformation – it inspires and directs acts of compassion, mercy, and justice (Levin 2009). Pathogenic or sick faith suggests itself as a font of psychopathology, which may have followed by negative somatic consequences and destructive behavior. Certain expressions of distorted religious faith may serve as a source of or may reflect psychological conflict (Levin 2009) and/or psychopathology. Distorted and pathogenic faith can indeed be an impediment to well-being and healing, no serious observer would deny this point (Levin 2009). Healthy-minded spirituality and religion are the wealth of nations. Public mental health is essential to the attainment of peace and security and religion may give a significant contribution in their promotion.

Global and public mental health promotion for compassionate society and empathic civilization: Wishful cooperation between religions and psychiatry

It is well known that religion may significantly affect determinants of public and global mental health. The evidence based and service user opinions suggest that spirituality and religion are of significance in clinical practice and research (Royal College of Psychiatrists 2013). Mental health promotion is the complex process of enabling people to protect, improve and promote their mental health at individual and collective level. From recently public mental health activities have focused more and more on enhancing a positive, meaningful, and engaged life rather than on the control and elimination of mental disorders (Fledderus et al. 2010). Positive mental health is more than the absence of ill mental health and mental illness. It is a resource that enables people to realize their goals, satisfy their needs, and to cope with the environment in order to live a long, productive and satisfying life. Widely acknowledged environmental and social resources for mental health include: peace, home safety, economic security, compassionate society, and a stable ecosystem. Public and global mental health promotion which strengthens these resources may significantly increase individual and collective/national well-being (see CDC 2016). Countries all over the world differ substantially in their levels of well-being as well as in the religiosity of their people. According to the moral code of all major religions one should avoid evil deeds (rage, cruelty, anger, pride, and envy) and practice virtues (empathy, compassion, kindness, gentleness, truthfulness, self-control, etc.). All these virtues may contribute to inner peace, satisfaction, well-being and ultimately to positive mental health. Both psychiatry and religion have the same goal, predicated on positive and optimistic view on human nature, to transform destructive behaviors into constructive ones leading to positive mental and spiritual health (Jakovljevic 2005, Boehmer 2016).

Selfish exploitation, violence, terrorism and war have become the huge source of, hate, violence, suffering, poverty and waste of human and nature resources, all associated with a lot of mental health problems and individual and collective psychopathology. The choice between clash of civilizations or creative dialogue among them has become a fundamental question, not only for global mental health but also for the very survival of mankind (see Jakovljevic & Tomic 2016). According to Staguhn (2007) „a human being seems to be floating over the abyss, in-between contradictories: war and peace, hatred and love, power and powerlessness“. According to Desmond Tutu (2014) "people are not born hating each other and wishing to cause harm. It is a learned condition." People are encouraged to engage in conflicts and wars by those benefiting from them, so that one should work on developing immunity to warmongers (Staguhn 2007). Vengeance has been claimed to be the very essence of human nature, but it can also be overcome by virtue of forgiveness. If we continue practicing the law of an eye for an eye, we will all end up blind (Tutu 2014). Civilization represents an attempt to confine the aggressive and revengeful part of human nature; great religions have made it their mission, too. With increasing globalization, mobility and migrations, the world is becoming a cosmopolis deeply interconnected so that what happens in one part of the world may have strong repercussions in other parts (the butterfly effect). This has led to an ideology of cosmopolitism, universalism and empathic civilization with renewed interest for thinking about what is it that human beings have in common, what is a real human nature, and to explore the ethical basis for it (see Ricard 2015).

From the global mental health perspective we have to recognize very fundamental fact about ourselves: we are a species that has evolved to thrive on love, kindness and compassion associated with our interconnectedness and interdependency (see Jakovljevic & Tomic 2016). Empathy is fundamental for establishing and maintaining all of our most significant relationships based on respect, trust, understanding, non-judging, and friendship (Krznaric 2015). Empathy, the essence of humanism and human condition, is social glue that holds humans together which is very important for survival. To empathize means to civilize and humanize, to civilize and humanize means to empathize (Krznaric 2014). With empathizing we see each other's humanity. Empathy leads to healthy, creative, flourishing and well-functioning families, communities, nations, societies and civilizations. Human beings are biologically wired to need connection, attachment, recognition, validation and belonging. Empathy is what enables us to extend our social affiliations and connect with other people in larger social, political, economic and religious units, cultures and civilizations. Public and global mental health is the product based on human rights, love, gratitude, reverence, empathy and compassion. Education for love, empathy and compassion are pillars and foundation of the global mental health and an esprit de corps of the empathic civilization of love (see Ferrucci 2007). The promotion of a dialogue among civilizations and creation of an empathic humanistic cooperative political culture may contribute to the development of global civilization of love and piece. Love, kindness, gentleness, and compassion are like basic food for our minds, they are intrinsically related to our well-being. Good news from the latest neuroscience research is that empathy and compassion can be taught, learned and cultivated. Envision a future in which economics, education, medicine, psychiatry, religion and even politics are infused with more empathy and compassion transforming our world. Empathy and compassion is an *esprit de corps* of the humanistic civilization of love and the creation of global

cosmopolitan society governed by law and order as well as of the promotion of global mental health. Global empathic civilization seems to be a key to the very survival of humankind and life on our planet. Psychiatry and religion in creative dialogues and joint projects as good partners can significantly contribute to the healing of our broken world and promoting compassionate society and empathic civilization.

Conclusions

Due to progress in post-secular dialogue, psychiatry, religion and spiritual disciplines have the historical opportunity to shape the future of individual, public and global mental health as well as to promote ideas of compassionate society and empathic civilization. The enduring task for both psychiatry and religion is to encourage people to live their lives with love, empathy and compassion.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. *Abu-Raiya H: On the links between religion, mental health and inter-religious conflict: A Brief summary of empirical research. Isr J Psychiatry Relat Sci 2013; 50:130-139*
2. *American Psychiatric Association (APA): Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5). Washington DC, 2013.*
3. *Aspinwall LG & Taylor SE: A stich in time: Self-regulation and proactive coping. Psychological Bulletin 1997; 121:417-436*
4. *Bloom W: The Power of Modern Spirituality – How to live a life of compassion and personal fulfillment. Piatkus, London, 2011.*
5. *Boehmer M: Does psychiatry need religion and spirituality in its treatment approach? Narcissism as an example. South African Journal of Psychiatry 2016; 22:http://dx.doi.org/10.4102/sajpsychiatry.v22i1.563*
6. *CDC (Centers for Disease Control and Prevention): Health-related Quality of Life – Well-being Concepts. 2016. https://www.cdc.gov*
7. *Dodge R, Daly A, Huyton J & Sanders L: The challenge of defining wellbeing. Int J Wellbeing 2012; 2:222–235. doi:10.5502/ijw.v2i3.4 CrossRefGoogle Scholar*
8. *Encarta Concise English Dictionary, Bloomsbury, 2001.*
9. *Fargain CA & Pargament KI: Strengthened by the spirit: Religion, spirituality, and resilience through adulthood and aging. In Resnick B, Gwyther LP & Roberto KA (eds): Resilience in Aging, 163-180. Springer, 2011*
10. *Feder A, Nestler EJ & Charney DS: Psychobiology and molecular genetics of resilience. Nat Rev Neurosci 2009 June; 10 (6):446-457. doi:10.1038/nrn2649*
11. *Fledderus M, Bohlmeijer ET, Smit F, Westerhof GJ: Mental health promotion as a new goal in public mental health care: A randomized controlled trial of an intervention enhancing psychologicyl flexibility. American Journal of Public Health 2010; 100:2372-2378.*
12. *Galanter M: Spirituality and the Healthy Mind – Science, Therapy, and the Need for Personal Meaning. Oxford University Press, 2005.*
13. *Griffith JL: Religion that Heals, Religion that harms – A Guide for Clinical Practice. The Guilford Press, New York & London, 2010.*
14. *Hatch S, Huppert FA, Abbot R, Croudace T, Ploubidis G, Wadsworth M, Richards M & Kuh D: A life course approach to well-being. In Haworth J & Hart G: Well-being: Individual, Community and Social Perspectives, 191-209. Palgrave Macmillan, 2012.*
15. *Huguelot P & Koenig HG (eds): Religion and Spirituality in Psychiatry. Cambridge University Press, 2009.*
16. *Jakovljević M: Current status of religion and psychiatry. Psychiatr Danub 2005; 17:138-140.*
17. *Jakovljevic M: Duhovnost u suvremenoj medicine i psihijatriji (Spirituality in Contemporary Medicine and Psychiatry). Pro Mente d.o.o., Zagreb, 2010.*
18. *Jakovljevic M: Psychiatry at the crossroad between crisis and new identity. Psychiatr Danub 2012; 24(suppl 3):267-271.*
19. *Jakovljevic M: Public and global mental health promotion for empathic civilization: A new goal of Psychiatria Danubina. Psychiat Danub 2016; 28:312-314.*
20. *Jakovljevic M & Tomic Z: Global and public mental health promotion for empathic civilization: The role of political psycho-cultures. Psychiatr Danub 2016; 28:323-333.*
21. *Jakovljevic M: Psychiatry and religion: Opponents or collaborators – The power of spirituality in contemporary psychiatry. Psychiatr Danub 2017a; 29(suppl 1):s82-s88.*
22. *Jakovljevic M: Placebo and nocebo phenomena from the perspective of evidence based and person centered medicine. Hospital Pharmacology – International Multidisciplinary Journal 2017b; 4:512-20, in press (www.hophonline.org)*
23. *James W: Raznolikosti religioznog iskustva (The Varietes of Religious Experience – The Modern Library, New York, 1936). Naprijed, Zagreb, 1990.*
24. *Jeste DV, Palmer BW, Rettew DC, Boardman S: Positive psychiatry: its time has come. J Clin Psychiatry 2015; 76:675-683. doi:10.4088/JCP.14nr09599 CrossRefPubMedGoogle Scholar.*
25. *Joshi S & Kumari S: Religious beliefs and mental health: An empirical review. Delhi Psychiatry Journal 2011; 14:40-50.*
26. *Kradin R: The Placebo Response and the Power of Unconscious Healing. Routledge; Taylor & Francis Group, New York & London, 2008.*
27. *Levin J: How faith heals: A theoretical model. EXPLORE 2009; 5:77-96.*
28. *Levin J: Religion and mental health: Theory and research. Int J Appl Psychoanal. Studies 2010; published online in Wiley InterScience (www.interscience-wiley.com). doi:10.1002/aps.240*
29. *Loewenthal K: Religion, Culture, and Mental Health. Cambridge University Press, 2007.*
30. *Pickering J: Is well-being local or global? A perspective from ecopsychology. In Haworth J & Hart G: Well-being: Individual, Community and Social Perspectives, 153-166. Palgrave Macmillan, 2012.*
31. *Prilleltensky I & Prilleltensky O: Webs of well-being: The interdependence of personal, relational, organizational and communal well-being. In Haworth J & Hart G: Well-being: Individual, Community and Social Perspectives, 61-78. Palgrave Macmillan, 2012.*

32. Reutter KK & Bigatti SM: Religiosity and spirituality as resilience resources: Moderation, mediation, or moderated mediation? Journal for Scientific Study of Religion 2014; 53:56-72.
33. Ricard M: Altruism: The Power of Compassion to Change Yourself and the World. Atlantic Books, London, 2015.
34. Royal College of Psychiatrists: Recommendations for psychiatrists on spirituality and religion. Position Statement PS03/2013. London, 2013.
35. Russo SJ, Murrough JW, Han MH, Charney DS & Nestler EJ: Neurobiology of resilience. Nat Neurosci 2012; 15:1475-1484. doi: 10.1038/nn.3234
36. Senge PM: The Fifth Discipline – The Art and Practice of the Learning Organisation. Random House, London, 2006.
37. Shin SJ, Yung DY & Hwang EA: Concept analysis of resilience in patients with cardiovascular diseases. J Korean Acad Nurs 2009; 39:788-795. https://doi.org/10.4040/j kan.2009.39.6.788
38. Slade M: Personal Recovery and Mental Illness – A Guide for Mental Health Professionals. Cambridge University Press, 2011.
39. Staguhn G: Knjiga o ratu – Zašto ljudi ne mogu živjeti u miru? (Warum die Menschen keinen Frieden halten. Eine Geschichte des Krieges). Mozaik knjiga, Grupa Mladinska knjiga, Zagreb, 2007.
40. Tutu D & Tutu M: The Book of Forgiving: The Fourfold Path for Healing Ourselves and Our World. Harper One, 2014.
41. World Health Organization, WHO (2014) Mental health: a state of well-being. http://www.who.int/features/factfiles/mental_health/en/. Accessed 1 January 2016
42. World Health Organization, WHO (2009) Mental health, resilience and inequalities. http://www.euro.who.int/data/assets/pdf_file/0012/100821/E92227.pdf. Accessed 2 February 2016

Correspondence:
Professor Miro Jakovljevic, MD, PhD
University Hospital Centre Zagreb, Department of Psychiatry
Kišpatićeva 12, 10000 Zagreb, Croatia
E-mail: psychiatry@kbc-zagreb.hr