Religion, Culture and Mental Health

Kate Loewenthal

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Are religious practices involving seeing visions and speaking in tongues beneficial or detrimental to mental health? Do some cultures express distress in bodily form because they lack the linguistic categories to express distress psychologically? Do some religions encourage clinical levels of obsessional behaviour? And are religious people happier than others? By merging the growing information on religion and mental health with that on culture and mental health, Kate Loewenthal enables fresh perspectives on these questions. This book deals with different psychiatric conditions such as schizophrenia, manic disorders, depression, anxiety, somatisation and dissociation as well as positive states of mind, and analyses the religious and cultural influences on each.

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Note about 'G-d'

When you start reading, and wonder about 'G-d', here is the explanation. I could write a book of stories solely about my adventures as an author writing on the psychology of religion, who is also an orthodox Jew, and who wishes to follow the prescription of Jewish law not to write out any name of G-d in full. One reason for this prescription is to avoid the possibly of a sacred name finishing up in a place which is not fitting or respectful, euphemistically termed a rubbish heap in some sources of Jewish law. Probably a cesspit or similar is the horrible fate devoutly to be avoided. Some editors and publishers have chosen to edit in the full name of G-d to avoid confusion on the part of the reader. For this book, the reviewer and editors have decided that readers are unlikely to be confused or irritated by 'G-d', or 'L-rd'. This note is to explain why.

1 Introduction

Some questions

This chapter raises some questions about the relations between religion, culture and mental health.

Does religion cause, exacerbate or relieve mental disorder? And what role is played by cultural factors in the relations between mental health and religion? Are religion's roles in mental health similar in every culture?

An underlying task for this book and its readers is to examine several prevalent ideas and questions about religion and mental health. Are these ideas misconceptions, or distortions or distillations of important truths? They include:

- Do visions, voices and delusions always mean that the person reporting them is mad? If religions encourage them, are their adherents putting themselves at risk of going mad?

  Eliza is a devout Christian. Every morning and evening she studies passages from the Bible, and prays – speaking to G-d in her own words. When she is very worried or upset she sometimes cries, feeling that it is quite safe to do so, and that G-d understands. Sometimes she hears a gentle voice saying comforting things – 'Eliza, Eliza', 'It's OK.' 'Keep trusting me.'

  Sometimes in the night John feels he is awake but unable to move, and he is conscious of a presence in his room. He can see a grey shape, not a human shape, just a roundish slightly foggy mass, moving towards him. It stops near his bed and seems to remain motionless for perhaps five or ten minutes, and then it goes away. It is not pleasant at all. He feels it is some kind of malign spiritual or ghostly presence.

  Neither Eliza nor John wants to talk about their experiences to the people they know. They are worried that people will think

they are mad, even though – as we shall see – the experiences of neither would be regarded as true symptoms of psychosis. Might visions, voices and delusions be precursors of psychosis? We can ask whether, if religions encourage and support experiences involving visions and voices, might this be dangerous for some people?

- Might religious factors play an important role in the commoner psychiatric disorders?

Jean doesn't want to pray any more. She is sleeping badly and cries a lot, and feels that life is not worth living. She can't pray. Why should she? It is just empty words, and she doubts that G-d is there. If he is, he doesn't seem interested in her and her problems.

Asma is having trouble praying. She is sleeping badly, and cries a lot, and feels that life is not worth living. She does pray but her troubles continue and she wonders whether there is something wrong with her. Perhaps she is not good, and that is why Allah does not seem to listen to her prayers.

Are the depressive states suffered by Jean and by Asma made worse by their difficulties with prayer? Would they be at least a little better off if there were no such issue? How does Jean's Christian background and Asma's Muslim background affect the role played by prayer in their depression?

As we shall see in chapter 4, there are people who find that prayer can be helpful in alleviating distress – if so, what has gone awry for Jean and Asma?

- Might religious factors promote mental health?

Janet has big problems at work. She loves her job as a social worker, and in spite of the horrific circumstances of some of the families on her caseload, she is genuinely pleased to feel that sometimes she is able to make a difference for the better. But Janet has a difficult manager. The manager is always picking holes in what Janet has done, and has returned a negative review of Janet's performance. Janet feels so helpless. She fears that her work is not valued and that her word is less likely to be accepted than her manager's. Janet has been to talk to her minister, who gave her some sensible advice about ways of handling the problem. He suggested that she talks to senior management, that she tries to stay calm and pleasant whenever she discusses the issue – and he also suggested (rather diffidently) that she might call on her reserves of religious faith, trusting that whatever happens will be for the best. Janet found all this helpful.

Did Janet feel helped simply because her minister was there for her, to listen to her problems, or because of the sensible suggestions about dealing with interpersonal issues, or because of the specifically spiritual aspects of his advice? Would she have worked out solutions to her difficulties anyway, either by herself, or with some source of support that was not specifically religious?

- Are people in some cultures more likely to express distress physically rather than psychologically – and might religious factors play a role in the bodily expression of distress?

Jono came to work in Europe, in the hope that he would be able to send some money to his wife and children, and also save something to enable them to buy some land and build a house when he returned home. The work he found is hard, uninteresting and poorly paid, but for several months he managed to survive. He shared a room with other workers from his country, and managed to eat enough, send money home to his family, and even to save a little. He was happy that things were working out and looked forward to returning home in a few years. Then he developed a very bad stomach upset and was unable to work. The doctor gave him medicine but it did not help. Jono began to worry in case a jealous enemy was working a bad magic to make him ill. The stomach pains and other symptoms became worse. He could not work, so he could not save and had no money to send to his family. Someone told him about a healer from his country who might be able to help. Jono paid the healer quite a lot of money from his savings and the healer made some special prayers and gave him an amulet to protect him. Jono still doesn't feel well but he has gone back to work because he is so worried about money. But he is not working well because he is in pain and has other symptoms which interfere with his work. If he has to stop work again he will try both the doctor and the healer again. Maybe the doctor has stronger medicine or an operation, maybe the healer has stronger prayers or a better amulet.

Jono's condition illustrates the way bodily complaints and stress can have a very nasty spiralling effect. His condition also highlights a common scenario – when Western medicine fails, or sometimes before Western medicine is tried, culturally carried religious beliefs and practices about illnesses and cures may be invoked. Do these help, or hinder, or have no effect? And are somatic complaints and/or attributing them spiritual causes more common in some cultures than in others?

- Can we distinguish between religious trances and states of spirit possession, and dissociative disorders?

Lou had seemed morose and miserable and withdrawn to his workmates. Then he seemed to become more outgoing. He exchanged friendly greetings, smiled more, and started to chat with others now and then. He told his workmates that he had found the Lord, and felt that his life had been turned around. Some of his workmates scoffed, some were a bit curious, and one or two were even a bit impressed. Brian was scornful but a bit curious, and asked Lou exactly what had happened. Lou persuaded Brian to come along to a service and see for himself. Brian went along, listened to the preacher, heard everyone singing and praising the Lord, and then some people began speaking in a strange way, a kind of babbling – he couldn't understand what they were saying. They looked quite happy. Lou was one of them. Eventually, Brian began to feel that he had seen and heard enough so he tried to thank Lou and told him that he was going home, but Lou seemed to be in some kind of a trance and Brian wasn't sure whether he had taken it in, though he seemed to smile and nod in acknowledgement while continuing to 'speak in tongues'. Brian went home thinking to himself that it all seemed a bit over the top and he couldn't imagine himself getting carried away like that.

Brian thinks that Lou and his co-religionists are over the top, but he doesn't think they are really mad. Lou is in a somewhat dissociated state, but he seems to have some awareness of what's going on around him, and he isn't doing anything dangerous to himself or to others. So is his behaviour really disordered? Are dissociative states equally encouraged in different religious and cultural groups, and what are their effects? These questions and others will be considered in the chapters that follow. The questions above were illustrated with hypothetical vignettes, based on real-life situations. In the ensuing chapter we will be considering actual case material based on clinical experience and research interviewing. Before this, we need to look at some definitions of culture, religion and mental health.

Definitions of culture, religion and mental health

Culture

The Victorian anthropologist Tylor (1871) defined culture as 'that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society'. This definition has been very popluar. Over a hundred years later, the social psychologists Kenrick, Neuberg &

Cialdini (1999) defined culture in very similar terms, as 'the beliefs, customs, habits and language shared by the people living in a particular time and place'.

There have been concerns about the vagueness and overinclusiveness of the term culture and the kind of definition advanced by Tylor (Manganaro, 1922; Greenblatt, 1987), but writers on cultural psychiatry and psychology have continued to use it in the general sense offered above.

These rather short definitions could be acceptable as a framework to work with, for our purposes in this book. I believe this kind of definition is acceptable because we are not here – me writing and you reading – to unpick the concept of culture. We simply need to understand how the term has been used by social scientists and by psychiatrists. In studies of culture in relation to psychiatry and psychological factors, the commonly used label for a particular social-cultural group is normally adopted; for example, 'Chinese', 'Saami', 'Norwegian', 'Banyankore' were among many terms used to denote the ethnic/cultural/social groups studied in one recent number of the journal *Transcultural Psychiatry*. Published reports then go on to describe those aspects of culture (beliefs, collectively shared memories, behaviour, etc.) which appear to be relevant to the mental health problem under discussion.

With religion, however, there is a wide range of measurement available, of different aspects of religious belief, feeling, motivation, experience and behaviour. We need to note something about this variation. Because of the range of ways in which 'religion' has been defined and measured, we cannot make general inferences about the relations between religion and mental health. We need to know which aspect of religion is under examination when considering findings and conclusions.

Religion

Religion is hard to define in a way that is satisfactory to most people most of the time. Wulff (1997) suggests that a 'satisfactory definition (of religion) has eluded scholars to this day'. Smith (1963) suggested that the noun religion is 'not only unnecessary but inadequate to any genuine understanding'! Brown (1987) spent more than a hundred pages on the problems of defining, analysing and

measuring religion and its many parameters. Capps (1994) has argued that the definitions of religion offered by eminent scholars reflect the personal biographies of those scholars.

Attempting to come to earth, here is a round-up of some attempts at defining religion. English & English (1958) suggested that religion is 'a system of attitudes, practices, rites, ceremonies and beliefs by means of which individuals or a community

- put themselves in relation to G-d or to a supernatural world,
- and often to each other, and
- derive a set of values by which to judge events in the natural world'.

Loewenthal (1995a) suggested that the major religious traditions have a number of features of belief in common:

- The existence of a non-material (i.e. spiritual) reality.
- The purpose of life is to increase harmony in the world by doing good and avoiding evil.
- The monotheistic religions hold that the source of existence (i.e. G-d) is also the source of moral directives.
- All religions involve and depend on social organisation for communicating these ideas.

All religious traditions involve beliefs and behaviours about *spiritual reality, G-d, morality and purpose*, and, finally, the *communication* of these. Some authors would include atheism, agnosticism and 'alternative faiths' as religious postures involving a relationship with G-d (e.g. Rizzuto, 1974).

A large range of measures have been used, particularly by psychologists, to assess styles of religiosity, religious beliefs and their strength and the style with which they are held, the varieties and importance and extent of different religious practices (see Loewenthal, 2000). Hill & Hood (1999) produced a very large compendium of measures of religiosity, mostly suitable only for US Christians. General measures of religiosity include:

- Affiliation: whether the person belongs to a religious group.
- Identity or self-definition: whether the person defines himself or herself as religious (or Christian, Hindu, Jewish, Muslim or whatever category the investigator is interested in).
- Belief in G-d.

Some examples of research measures of religion include:

- The Francis Scale of Attitude towards Christianity (Francis, 1993). It includes items such as: 'I know that Jesus helps me', and 'I do not think the Bible is out of date.' It has been very widely used.
- Measures of religious orientation, developed particularly by Batson, based on Allport & Ross (1967) (see e.g. Batson, Schoenrade & Ventis, 1993; Hill & Hood, 1999). Different religious orientations have been shown to relate differently to social attitudes such as racial prejudice, and to mental health, as will be discussed in chapter 4.
- In continental Europe an important set of measures of religiosity which has been explored in relation to both social attitudes and mental health includes measures of post-critical beliefs – the authors suggest that literal belief may be followed by critical beliefs, which may then be followed by post-critical beliefs, involving symbolism: relativism, or 'second naiveté' (Duriez & Hutsebaut, 2000). The concepts on which religious orientation measures are based stem from the work of Gordon Allport (1950), who was interested in personality style and development, and how this impacts on the way in which individuals are both religious and have ways of relating to others. The post-critical beliefs and related measures are derived from the work of Fowler (1981), who has further developed understanding of the ways in which faith develops, grows and changes.
- Littlewood & Lipsedge (1981a, 1998) developed different types of questions to discover the extent of 'religious interest' in psychiatric patients from different religious groups, particularly Christian and Jewish; for example, 'Did the miracles in the Bible really happen?' (for Christians) and 'Do you generally eat kosher food at home?' (for Jews).
- There is a growing number of measures of Muslim religiosity, such as the Muslim Attitudes towards Religion Scale (MARS) (Wilde & Joseph, 1997; Ghorbani, Watson, Ghramaleki et al., 2000).
- Loewenthal, MacLeod & Cinnirella (2001) developed a short measure of religious activity, which has been used with a wide range of religious traditions, including Buddhist, Christian,

Hindu, Jewish and Muslim, and including non-practising and non-affiliated.
- The Royal Free interview for religious and spiritual beliefs (King, Speck & Thomas, 1995). This measure is said to be appropriate for people who profess no religious affiliation, and/or who prefer to use the term spirituality rather than religion, as well as people with a wide range of more orthodox religious identities and beliefs.

Many other examples could be given, but these examples should be more than enough to underline the point that when 'religion' is under discussion and measurement, one or more of many possible aspects will have been targeted.

Mental health

As with religion, social scientific and psychiatric research can target one or more of many possible aspects of mental health.

Mental health be defined either 'negatively' by the absence of mental illness, or 'positively' by the presence of features said to be characteristic of mental health.

Mental health as absence of one or more specific psychiatric illnesses is an approach often taken in studies of religion. In the chapters that follow, different psychiatric conditions, and their relations to religious factors, will be discussed. The book will not examine the so-called "organic" disorders, such as Alzheimer's disease, for which there is a probable organic basis. It focus rather on the commoner psychiatric disorders, and those which have involved markedly religious features or implications. Each of chapters 2 to 7 will begin with an attempt at defining the psychiatric condition under discussion.

A more positive view of mental health involves the presence of positive states. This approach recognises that there is more to health than the absence of illness, and attempts are made to assess positive states or traits – usually psychometrically, by questionnaire-type methods. Measures include general positive well-being (e.g. Seligman, 2002), spiritual well-being (e.g. Ellison, 1983) and specific virtues and other positive states (Seligman, 2002). Chapter 8 examines positive states.

Throughout this book the aspect of religion and mental health assessed or under discussion in any particular study will be described.

How does culture affect the relations between religion and mental health?

Books and articles on the psychology of religion sometimes appear to be offering conclusions about the relations between religion and psychological factors as if these conclusions were culturally universal. In fact, most studies have been carried out in the USA, in a Christian culture, and generalisability is doubtful. Occasionally, there have been studies involving Jewish participants, and, especially recently, Muslim participants. Sometimes studies may report on European or Afro-American or other participants.

It is becoming increasingly clear that relations between religion and psychological factors are not the same in every culture. Thus Argyle & Beit-Hallahmi's (1975) classic *The Social Psychology of Religion* reviewed many studies of associations between religion and psychological factors and found that these relations varied in different social groups – relations between religion and mental health, for example, varied with social class, gender, religious denomination and other socio-cultural factors. More recently, Duriez & Hutsebaut (2000) concluded that (North) American studies tended to show a positive relationship between religion and prejudice, whereas in the Low Countries (the Netherlands, Belgium, Luxembourg) the relationship tends to be negative. Other examples could be given. But what about the relationships between culture and mental health?

Much has been written about culture and mental health. Important themes include:

- Attention to the question whether there are variations between cultures in the prevalence and incidence of different psychiatric disorders, and if so why.
- The description of psychiatric conditions which may be culture-specific.
- The understanding of the interpretive framework used in different cultures for the understanding of mental illness.

In addressing these and other questions, cultural and social psychiatrists and medical anthropologists very seldom consider religious factors separately from cultural factors. The focus is typically on the expression of psychiatric disorder in a particular cultural context, and religious aspects are part and parcel of that cultural context. Littlewood & Lipsedge (1989) note that religion may play a special role in the maintenance and development of cultural norms: 'the implicit goals of social conformity are frequently couched in the form of religious injunctions which are beyond question'. But in most studies of culture and mental health, religious factors are treated as part of the cultural package.

So there seem to be discipline-specific biases in the way the interactions between culture, religion and mental health have been studied. For (social) psychologists, these are three factors, often measured psychometrically, and their associations studied statistically, with culture and religion interacting or moderating each other's effects on mental health and other psychological factors. For (social and cultural) psychiatrists, religion is firmly embedded in culture, and the method of studying the relations between culture and mental health often use descriptive case material, or adopt a phenomenological or post-modernist stance towards understanding the perspectives of the members of the culture under study. Of course, psychologists may use descriptive material and adopt a phenomenological approach, and psychiatrists may use measurement, quantification and the study of the statistical association between factors. But the approaches of social psychologists and of social/cultural psychiatry can be broadly contrasted.

This book will attempt to merge the material from the different disciplines.

2 Schizophrenia

Definitions and symptoms, and an overview of causes and relations with religion

What is schizophrenia? How might it be affected by religious and cultural factors such as the value placed on visions in some religions?

Ann is 26, a trained commercial artist, and married to Henry with whom she had been going out since she was 18. Both found their marriage boring. Ann began going out dancing and met another man. As a Catholic, Ann could not consider divorce. But one evening she announced that she was going to marry the other man, go with him to South America and have twenty babies. She spoke very rapidly and much of what she said was unintelligible. She also said that she was seeing visions of the Virgin Mary, and in the office tried to get her colleagues all to kneel and say the rosary. When she was taken to see a priest, she spat at him. A psychiatrist recommended hospitalisation. (based on a case description in Comer, 1999)

Schizophrenia is a generic name for a group of conditions which come under the general heading of psychosis or madness. There is a serious deterioration of functioning, strange beliefs or experiences, inappropriate emotional states, and sometimes motor disturbances.

Emil Kraepelin (1896) distinguished two forms of insanity: dementia praecox and manic-depressive psychosis. He thought that sufferers from dementia praecox would gradually deteriorate, while people with manic depression would have periods of remission between psychotic episodes. He was convinced that psychoses were illnesses, and this view remains controversial, even today, when some feel that the illness label is inappropriate: Bentall & Beck (2004) have cogently argued this view in the light of much recent evidence. In 1913 Bleuler coined the term schizophrenia, to replace Kraepelin's

dementia praecox. The term schizophrenia has caused some confusion because lay people may believe that it implies a split personality (as in R. L. Stevenson's Dr Jekyll and Mr Hyde), whereas in fact Bleuler meant that different psychological functions were split from each other. Although the term schizophrenia is confusing, it has persisted.

For a diagnosis of schizophrenia, a person must have been having psychotic symptoms for at least a week, and show a marked deterioration of functioning in self-care, work or social relations. There would be no major changes in mood – no marked depression or elation. There should have been some disturbances for at least six months and there should be no evidence of an organic cause (drugs or a medical condition). What are the characteristic psychotic symptoms? For diagnosis of schizophrenia, these must include:

At least two of:

- Delusions
- Prominent hallucinations
- Incoherence, or marked loosening of association (in speech)
- Catatonic behaviour (rigid, frozen posture)
- Flat or very inappropriate affect (mood).

OR Bizarre delusions (for example, that one's thoughts are being broadcast).

OR Prominent hallucinations of a voice.

(from Lazarus & Coleman, 1995, based on DSM-IIIR)

The DSM-IV classification lists a large number of related disorders in the schizophrenia group:

- Schizophrenia
  - paranoid type
  - disorganised type
  - catatonic type
  - undifferentiated type
  - residual type
- Schizophreniform disorder
- Schizoaffective disorder
- Delusional disorder
- Brief psychotic disorder
- Shared psychotic disorder

- Psychotic disorder due to a medical condition
- Psychotic disorder due to substance abuse
- Other psychotic disorder.

This range of diagnoses could be important for some purposes, but for our purposes we might just bear in mind one distinction, suggested by Fenton & McGlashan (1994) and by Crow (1995), between type I and type II schizophrenia (though of course in reality not every person will be clearly of one type or another).

Type I schizophrenics typically present mainly the 'positive symptoms' – disordered thought and speech, delusions and hallucinations. They are said to have a relatively good adjustment prior to breakdown, often respond fairly well to traditional medication, and have a fairly good long-term outcome. Type II schizophrenia presents with few or no positive symptoms, showing predominantly 'negative symptoms': withdrawal, lack of self-care, flat emotional state, and speaking very little. Pre-morbid adjustment is relatively poor, and so, sadly, is response to medication. The long-term outcome may be less good for type II than for type I schizophrenia. It is suggested that the biological bases of the types of schizophrenia differ – type I schizophrenics generally show abnormal neurotransmitter activity, whereas type II schizophrenics are shown by fMRI and other methods of examining brain structures to have brain structures which differ from normal. Whereas Ann, described above, might be considered a type I schizophrenic, Richard, described below, might be type II.

After leaving the army, Richard held a job for two years, but he felt very low in self-confidence and suffered attacks of anxiety. Eventually, he gave up work and refused to look for another job, becoming slower and slower in dressing and taking care of himself. He stayed at home and when he went out was uncertain what to do and where to go – he saw signs guiding his behaviour, for example, red lights and arrows were seen as signs from heaven about which direction to go in. But he became so tortured by uncertainties, and so afraid of doing the wrong thing, that ultimately he stayed at home, in bed, unable to move, eat, speak or take care of himself. (based on a case description in Comer, 1999)

What causes schizophrenia? Few would dispute the by-now strong evidence that genetically, biochemically and in terms of brain structure there are biological predispositions to develop schizophrenic

illness, particularly under stress. Nevertheless, there are psychological features in schizophrenia, and some (but not all) psychological therapies can have an important role to play in alleviating symptoms and improving quality of life (Hingley, 1997; Garety & Freeman, 1999; Hornstein, 2000; Barnes & Berke, 2002; Pilling, Bebbington, Kuipers et al., 2002a, 2002b). Social factors may play an important role in precipitating schizophrenia – for example, some forms of stress (Brown & Harris, 1989; Leff, 2001; Myin-Germeys, Krabbendam, Delespaul & Van Os, 2003). More notably, the custodial environment of older traditional-type psychiatric hospitals is thought to have contributed significantly to the deterioration of inmates, causing 'iatrogenic' illness (literally, illness caused by treating for illness). So careful attention to social environment will be important in improving the quality of life and preventing deterioration among people suffering from schizophrenic disorders, and many sufferers can be enabled to lead a normal life.

You probably noticed that in both the brief case histories just given, religious beliefs and behaviour figured. However, there is no very strong evidence that religious beliefs and behaviours actually cause – or even exacerbate – the illness. We will be looking at the relations between religion and schizophrenia in some detail in this chapter, but at this point it is worth noting that although there are often religious symptoms in schizophrenia, religion as such is not clearly related to schizophrenia in correlational studies.

For example, a measure of psychoticism developed by the Eysencks (Eysenck & Eysenck, 1985) has been shown to correlate *negatively* with measures of religiosity (e.g. Francis, 1992; Lewis & Joseph, 1994; Eysenck 1998, Lewis, 1999). A more elaborate measure is of schizotypy (the Multidimensional Schizotypal Traits Questionnaire, Rawlings & MacFarlane, 1994), which assesses personality traits which might indicate prodromal schizophrenia, including discomfort in close relationships, and odd forms of thinking and perceiving. Schizotypy is reported to have more complex relations with a measure of religion, the Francis Scale of Attitudes to Christianity (Francis & Stubbs, 1987). In a study of several hundred British adolescents, Joseph & Diduca (2001) reported that when the subscales of the schizotypy questionnaire were examined, perceptual aberrations related positively to religiosity, but magical ideation and impulsive nonconformity related negatively to religiosity.

Thalbourne & Delin (1999) noted a common thread underlying creativity, mystical experience and psychopathology including schizotypy. They called this common factor transliminality, and they defined it as 'a largely involuntary susceptibility to . . . psychological phenomena of an ideational and affective kind'. Transliminality related to measures of religiosity, dream recall and mystical experience. This rather mixed bag of evidence from correlational studies confirms that there is no simple relationship between schizophrenia and possible predisposing traits, and religion. This research also highlights the difficulties – which we will be discussing later in this chapter – of distinguishing pathological from non-pathological visions and other experiences, often religious in meaning. It also draws attention to another theme, to which more attention is given elsewhere – the often reported beneficial effect of religion on mental health.

Visions, voices, delusions and schizophrenia

Experiences of things that are not 'really there', and beliefs about things that cannot really be 'true' – these can be risky to talk about. There are certainly grounds for being afraid that one might be thought mad. As we have seen, voices, visions and delusions can all qualify as positive symptoms of schizophrenia. Famously, in Rosenhan's (1973) study, volunteers got themselves admitted to psychiatric institutions solely by claiming that they had been hearing voices. Fellow-patients saw that these volunteers were fakes, but the psychiatrists did not, showing that visions and voices can indeed be taken as signs of madness. But we do know that many religious systems encourage unusual beliefs, and experiences of an alternative or higher reality. Could these affect sanity? Or could people with precarious mental health be attracted to religious movements which encourage bizarre beliefs and unusual experiences?

This section will explore the nature of visions, voices and delusions, and their roles in religion and in schizophrenia.

A delusion is a belief that appears – to others – to have no basis in truth. It may seem bizarre.

Ivan went to the front door, leaned out, and peered furtively up and down the street. 'They're there,' he said, sounding terrified. 'You can't see them. They're waiting round the corner.' 'Who?' I asked. 'The Russians. They have

ray guns. They're waiting for me. You must know about it. It's on TV; they are trying to get me. This cough I have, it's from their germ weapons. I'm very careful, but I can't always see them.' (based on an interview conducted by the author)

A schizophrenic delusion may involve feelings of grandeur, a belief that one is an important figure such as Jesus, Napoleon or the Messiah. Or that one is being persecuted – by germs or invisible rays, for example, or by faceless bureaucracy. Or that trivial events and signs refer to oneself and have special significance. Delusions may be collective – Festinger, Riecken & Schachter (1956) described a religious sect, the Seekers, who believed that the world would be flooded and destroyed, and that only the Seekers would be rescued, by spaceships from another planet. As we shall see, mystical and other religious experiences have some features in common with psychotic experiences – delusions, hallucinations, feelings of depersonalisation – and it is a continual source of puzzlement how and whether we can always tell whether a particular experience is religious or psychotic (Dein & Loewenthal, 1999; Kemp, 2000; Leff, 2001; Bartocci, 2004)

Visions and voices are experiences 'as if' what is seen or heard is there, although usually the person is aware that the experience is hallucinatory. Bereaved people commonly see and/or hear the loved one, for example, sitting in a customary chair, or offering advice or comment. People experiencing hallucinations are commonly concerned that they may be taken as insane. There are support networks of people who hear voices or see visions.

May is in her seventies. She had a long and contented marriage to Owen, but he died from a heart attack six months ago. May has been feeling very low, but she is slowly taking more interest in her church activities, in her grandchildren, some of whom live near by, and in her gardening. About two weeks after Owen died, she saw him standing in the hallway, as she was making her way upstairs to bed. 'Goodnight love,' he said. May was startled, and when she looked again, he had gone. Since then she has seen and heard him several times, always fleeting, and always affectionate. The experiences seem to be getting less frequent. She did mention this to her minister, who said it was certainly nothing to worry about, and was something that often happened. She feels that wherever Owen is he is still her husband and loves her. She finds the experiences comforting, though she would not mention them to her friends and family. (based on an interview conducted by the author)

May's visions are a normal aspect of bereavement, experienced by many, though not all, bereaved people. But we have seen that visions, voices and delusions can all be positive symptoms of schizophrenia. Prior to overt illness, people who have suffered a schizophrenic breakdown normally report negative symptoms (low mood, sleep disturbance and social withdrawal) followed by fleeting positive symptoms (suspiciousness, thought disturbance, hallucinations) in the year or two preceding breakdown (Klosterkotter, 1992; Yung & McGorry, 1996; Moller & Husby, 2000). We also know that visions, voices and 'delusions' (bizarre beliefs that appear impossible or unlikely to be true) are encouraged in some religious systems.

Is it possible that by encouraging unusual beliefs and experiences, religion could in some cases be contributing to psychotic breakdown? Is it possible that schizophrenics are drawn towards religious movements that encourage and support people prone to have bizarre experiences? Chapter 3 describes some examples of people of whom it was suggested that religious factors might have precipitated a manic episode. The cases in chapter 3, though many involve reported beliefs that could be seen as delusory, suggest that if religious beliefs can precipitate any psychotic disorder, the features are more those of mania than schizophrenia. Second, we cannot be sure whether, even if these people were insane, they were not already in a susceptible state. Has religion ever been suggested as causing or exacerbating schizophrenia, rather than a mood disorder? The Jerusalem syndrome (Witztum & Kalian, 1999; Kalian & Witztum, 2002) shows many of the features of the cases of 'religious mania' described in the following chapter, but it has sometimes been suggested to be a culturally and religiously specific form of paranoid schizophrenia. The person exhibiting the Jerusalem syndrome is often a devout Christian, inspired by dreams and visions to travel to Jerusalem.

Birgitta Bergersdotter (St Bridget of Sweden), a highly educated and pious woman from an aristocratic Swedish family, began receiving visions after the death of her husband. She travelled to the Holy Land and received revelations there, ordering her to travel to Rome and speak to the pope and emperor 'words that I shall say to you'. While in Rome, Birgitta became heavily involved in politics, inspired by her visions, and founded an order of nuns. (described in Kalian & Witztum, 2002)

Birgitta and others were seen as 'heroic and extraordinary historical figures', and there is often little evidence of psychiatric illness. But others may show signs of psychiatric illness.

> Dennis Rohan was an Australian sheep shearer and a Pentecostalist. His group believed in the literal fulfilment of biblical prophecies, particularly the return of Israel to its homeland and the rebuilding of the Temple as a precondition for the coming of the Messiah. Dennis travelled to Israel, where he stayed on a kibbutz, and was noticed to be becoming increasingly unkempt and neglecting his studies. He set fire to the El Aksa mosque (built on the site of the first and second Temples) in 1969, causing demonstrations and riots in Arab capitals. Dennis believed that he had been chosen to rebuild the Temple, and that he should do this by destroying the El Aksa mosque. He believed that he would then become the ruler of Judea. (described in Lipsedge, 2003)

Such malign forms of the Jerusalem syndrome have led to dispute about whether the syndrome is a distinctive psychiatric syndrome (Fastovsky, Teitelbaum & Ziskin, 2000) involving a transient psychotic episode. Kalian & Witztum (2000) suggest that a paranoid schizophrenic or other psychotic illness is already present, brought to a head by contact with the Holy City, a crux of religious belief.

It would seem, then, that while visions and religious beliefs/delusions can play a role in precipitating episodes of psychiatric illness in people who are already prone, they are often part of normal experience, including religious experience, and are unlikely to be intrinsically pathogenic.

Perhaps there are differences between pathological visions and delusions, and religious visions and delusions? Peters, Day, McKenna & Orbach (1999) marshal the arguments that 'certain groups of people have similar experiences to the positive symptoms of schizophrenia' (notably delusions) 'but remain functioning members of society, such as those with profound religious experiences' (Jackson & Fulford, 1997). Peters et al. compared members of two types of religious groups (New Religious Movements, or NRMs, and Christians) with non-religious people, and with psychotic patients suffering from delusions. The NRM members were drawn from the Hare Krishna group and from a Pagan order (Druids). Two measures of delusional thinking were used in this study (which included factors such as persecution, paranormal beliefs and religiosity). The main findings and conclusions from this study were:

- Individuals from the NRMs scored higher than the Christians and the non-religious on the delusions measures, but scored similarly to the deluded, psychotic group. This score included a measure of 'florid, psychotic symptoms . . . rarely endorsed in the normal population' (the Delusions Symptoms-State Inventory, DSSI, Foulds & Bedford, 1975).
- NRM members were, however, less distressed and preoccupied by their delusional experiences than were the psychotic patients.
- The Christians did not score higher than the non-religious on the delusions measures, which suggests that religious beliefs per se do not account for delusional thinking.

Peters et al.'s study used a 21-item measure of delusions (PDI: Peters, Day & Garety, 1996; Peters, Joseph, Day & Garety, 2004) based on the Present State Examination (Wing, Cooper & Sartorius, 1973), which assesses 11 factors:

- Religiosity
- Persecution
- Grandiosity
- Paranormal beliefs
- Thought disturbances
- Suspiciousness
- Paranoid ideas
- Negative self
- Catastrophic ideation
- Depersonalisation
- Thought broadcast.

Looking up and down that list, there are several factors that might be encouraged by one or other religious groups – and religiosity probably by all! It is intriguing therefore that the Christians were not higher than the non-religious on the PDI, and it would be interesting to see whether there were differences on the individual PDI subscales. But Peters et al.'s main conclusions are worth noting: that New Religious Movement members were as convinced as the psychotic patients that their delusional ideas were true, and they had just as many such ideas, but their ideas were less florid, and they were not as preoccupied with them, or distressed by them.

A study by Getz, Fleck & Strakowski (2001) compared religiously active and religiously inactive psychotic patients. Religious delusions were more likely among the religiously active than among those who were religiously inactive, but the delusions were not more severe. Another study reported by Hempel, Meloy, Stern et al. (2002) discussed glossolalia (speaking in tongues) in a forensic setting. The glossolalists' delusions, hallucinations and crimes were predominantly of a religious and sexual nature, although glossolalia in non-clinical and non-forensic groups has been reported by users as calming and consoling (Malony & Lovekin, 1985; Grady & Loewenthal, 1997).

Davies, Griffiths & Vice (2001) compared experiences of auditory hallucinations in psychotic (schizophrenics in remission), evangelical and control (non-psychotic, non-evangelical) groups of participants. Of great interest is their finding that more than one-quarter of the control participants reported auditory hallucinations (27%). There were some differences from the Peters et al. findings, the most striking difference being that the average rating of hallucinatory experiences, even among the psychotic group, was somewhat positive. This may be a result of differences in the samples used – Davies et al.'s psychotic participants were in remission – and also perhaps of the different experiences being reported on: the Davies et al. study focused on auditory hallucinations rather than the huge range of delusions covered in the Peters et al. study. But a key finding in both studies was that the schizophrenic experiences of hallucinations were less pleasant than that of the other groups.

A further study on this theme was a study (Jones, Guy & Ormerod, 2003) in which participants were asked to sort descriptions of their experiences of hearing voices. Some participants were mental health service users, others were from a network of voice hearers. Again, the mental health service users were more likely to find the voices frightening, and to perceive voice hearing as a negative experience, than were others. However, non-mental health service users also found managing the voices difficult, even though their experiences were more positive.

A recent large study in the Netherlands (Hanssen, Bak, Bijl et al., 2005) showed that experiences of hallucinations and delusions – the so-called positive psychotic symptoms – are about 100 times as likely in the general population as the incidence of psychosis as such, and

Table 2.1 *Changes in religious activity among first-onset schizophrenia patients (adapted from Bhugra, 2002) (% in brackets)*

	White	Asian & Afro-Caribbean
More religious	0	14 (13%)
No change	36 (100%)	90 (87%)

that most people who report such experiences are unlikely to suffer psychotic illness. However – consistent with other evidence reviewed here – psychotic breakdown was more likely if hallucinations and delusions were unpleasant and intrusive.

These studies strengthen the view that there are specific qualities to the visions, voices and delusions of the psychiatrically ill, even before the onset of the illness. Although their content may be influenced by religious ideas, their quality, in particular their controllability and unpleasantness, is almost certainly the result of psychosis rather than religion.

Thus religious delusions and experiences are not in themselves inherently psychotic, but when they do appear in people suffering from psychotic illness, they have a more frightening and uncontrollable quality than the experiences of non-psychotic individuals.

However, there is still at least one major question, highlighted by Siddle, Haddock, Tarrier & Faragher (2002a). They compared schizophrenic patients with religious delusions with patients reporting other types of delusions. They found that the patients with religious delusions appeared to be more severely ill: they reported more symptoms, were functioning less well, and were being given more medication. Are the religious delusions making them more ill, or are those who are more ill in some way attracted to religious ideas?

Bhugra (2002) argues that the latter may be the case. When he examined the religious histories of patients with first-onset schizophrenia in London, he found that a high proportion reported that they had changed their religion, and also reported an increase in religious activity. This, however, was true only for ethnic minority patients.

Bhugra argues that self-concept, self-esteem and acceptance play a key role in structuring beliefs, and then in accepting or rejecting

them. He suggests that being in a racial or religious minority is likely to lead to emotional or psychic disturbance (Rosenberg, 1962) largely due to experiences of discrimination and prejudice including taunting and other forms of hostility. This feeling of disempowerment leads to a search for improved self-concept, self-esteem and acceptance. Religious groups and beliefs may offer feelings of psychological transformation, healing and rebirth. We cannot be sure, from Bhugra's argument, that it was the pre-morbid *schizophrenic* state that was a factor in attracting people to religion, rather than a more general emotional malaise. It is interesting that Siddle, Haddock, Tarrier & Faragher (2002b) bring some evidence to show that religious coping beliefs may be higher among psychiatric patients who are more ill, and religious coping beliefs can decline when symptoms improve. From this and other evidence, it would seem that religious beliefs may be two-edged weapons – while offering comfort, they may be a factor in suggesting or condoning bizarre or dangerous behaviour.

From a different perspective, using an analysis of persecutory beliefs and safety behaviours, Freeman, Garety & Kuipers (2001) have shown that emotional distress, including anxiety and low self-esteem, contributes to the maintenance of delusions and the use of safety behaviours. Thus a person suffering from persecutory delusions may feel that they have to take measures to protect themselves. Ivan, described earlier in this chapter, took to carrying an array of weapons when he went out of the house, and in 2005 I read a UK newspaper report of a man who felt that he had to defend himself against a friend's horseplay by bludgeoning him to death and dismembering him. Although Freeman et al. report that safety behaviours often consist of avoidance – Ivan feared that enemies were waiting with ray guns, was very reluctant to leave his house and in fact seldom did so – but they can be very dangerous. Hence forensic psychiatry and politics are heavily concerned with safety behaviours. Garety has led a school of thought which attempts to make delusional beliefs and their associated behaviours intelligible. Perhaps when their content involves an unfamiliar belief system, delusions become less intelligible and more crazy in the eyes of the beholder: 'Voodoo curse led me to stab wife' said a UK newspaper headline in 2005. A husband firebombed the home where his wife and children lived, and stabbed his wife with a bread knife when she and the

children jumped out of an upstairs window on to a mattress provided by helpful neighbours. When arrested, the man quoted Bible passages to the police, and said that he was under a voodoo curse.

On a less florid level, common religious safety behaviours include prayer and protection rituals. Siddle et al.'s work suggests that these may increase under stress, sometimes alongside symptoms of distress, as the unfortunate stressed person struggles to cope. This can give a very confusing picture about the relations between religion and psychiatric symptoms.

Before leaving this sometimes rather frightening area of human experience and behaviour, it is probably important to note that mystical experience – reported feelings of unity, of fundamental reality (Stace, 1960; Hood, 1975) – tends to be associated with feelings of well-being (Diener, 1984; Byrd, Lear & Schwenka, 2000). The Peters et al. delusions inventory, described above, includes a measure of depersonalisation, which would very likely be scored quite highly on by someone engaged in mystical experiences and practices. Kroll, Bachrach & Carey (2002) take up a suggestion of Hartmann's (1991), distinguishing between people with thin and thick (psychological) boundaries.

Thin-boundaried individuals are open, trustful, sensitive and empathetic, open to positive daydreaming and hypnotic states, and altered states of consciousness – and are more likely to believe in and to pursue the transcendental world and mystical and ecstatic religious experiences. They may be – often mistakenly – judged as hysterical. In particular, Kroll et al. suggest that medieval mystics should not be judged outside their supportive historical context, which endorsed particular religious states. Thus Angela of Foligno (1248–1309), in states of religious ecstasy, would

> fall to the ground and lose her powers of speech, or would cry out without shame 'Love still unknown, why do you leave me?' However, 'These screams were so choked up in my throat that the words were unintelligible.' (quoted in Kroll et al., 2002, p. 87)

We need not labour the point: there is growing evidence that a wide variety of religiously encouraged or religiously flavoured experiences may not be unpleasant or dangerous, or produce psychological illness, and may even be beneficial, even though they might sometimes be described as 'delusional'. We cannot be sure that all such beliefs

and behaviours are risk-free, psychiatrically. The consensus seems to be that where psychosis follows religious experience, the psychosis is more likely to be mood disorder (mania) than schizophrenia, as we shall see in the next chapter, and it is likely that the person was a vulnerable individual, with a previous history of either psychosis or a pre-morbid personality.

Spirit possession, demons

We leave a sometimes rather frightening area of human experience, and seem to be out of the frying pan into the fire. In what follows we examine experiences of and beliefs about demons, evil spirits and black magic. No one would seriously argue that these are anything other than terrifying – even if one does not share these beliefs, they are clearly terrifying for those who have been affected by a horrible affliction and who believe that it is the result of a curse or evil spirits. Psychodynamic theorists would say that they represent embodiments of our deepest terrors (Greenberg & Witztum, 2001). How widespread are these experiences and beliefs? How often do they occur in schizophrenia? To what extent is schizophrenia blamed on evil forces? And – to get into a really involved possibility – might schizophrenia be caused or exacerbated by beliefs in or experiences of evil forces? Can some of this knowledge be deployed in treatment?

How widespread are experiences of and beliefs about spirit possession and demons? And how often do they occur in schizophrenia? Anthropological sources suggest that beliefs in demons, black magic and evil spirits as causes of mental illness and distress are common to most societies (Dein, 1996). They may be less prevalent in Western countries, but even in Switzerland, Pfeifer (1994) found that more than one-third of 343 people attending a psychiatric outpatients clinic thought that their condition might have been caused by evil spirits, labelling this as occult possession, or bondage. Nearly one-third of the patients surveyed had sought help through ritual prayers or exorcism, designed to rid them of the unwelcome spiritual forces. In Singapore nearly one-third of the women psychiatric patients interviewed by Kua, Chew & Ko (1993) said that their illness was caused by a spirit, or by a charm which had been cast upon them. These patients were all Chinese, mainly Buddhist, Taoist or Christian, and were mainly suffering from depressive or anxiety disorders,

with only 14% of the sample suffering from psychotic disorders. In this study notably fewer men (11%) than women (31%) believed that their illness had been caused by spirits or charms, but similar proportions of men and women (about one-third) had consulted a traditional religious/spiritual healer before coming to the hospital where they took part in Kua et al.'s study. These studies support the view that beliefs in bad spiritual forces as causes of psychological disturbance are not uncommon, but they are not exactly normative in the populations studied.

Of course, the proportions could have been affected by the fact that in both studies the people interviewed were suffering from psychiatric illness, and by the fact that they were being interviewed in an orthodox Western-style psychiatric hospital, by psychiatrists. It is possible that many believers in spiritual forces as causes of psychiatric illness may never get to see a psychiatrist, especially if their condition improved after treatment by a religious/spiritual healer. Even if they do consult a psychiatrist, they may not wish to admit these beliefs to the psychiatrist. Srinivasan & Thara (2001) thought, very credibly, that the causal attributions made about the causes of schizophrenia by the families of 254 people suffering from schizophrenia in India were 'rational and understandable', given the lack of exposure to information about schizophrenia. Only 12% thought that a supernatural cause was involved, and only 5% thought it the only cause. Most commonly, psychosocial stress was named as a cause, followed by personality defect and heredity. Similar beliefs about causal factors in psychiatric illness (schizophrenia and depression) among non-clinical groups of Christians, Hindu, Jewish and Muslim women in the UK, were reported by Loewenthal & Cinnirella (1999). Where spiritual causes were mentioned, these were often specified as involving lack of faith. Interestingly, religious factors were less often cited as possible causes for schizophrenia than for depression in this study – but the women interviewed were asked for their spontaneous views, and spirits and supernatural forces figured negligibly in their accounts. As in the Srinivasan & Thara study, stress and personality factors were most often seen as important.

Spirit beliefs certainly need not cause psychiatric illness. A striking example involves a widespread phenomenon – sleep paralysis – which is common to all cultures, and which is usually interpreted

as involving experience of spiritual forces or entities, often malign. Sleep paralysis is distinct from nightmares and night terrors, and is thought to involve the muscular paralysis characteristic of REM sleep (Rapid Eye Movement sleep, in which dreaming is common and voluntary muscles are relaxed) while the individual is in a state of wakefulness. The experience seems to be universally unpleasant.

> The person feels as if they are completely awake, but unable to move their limbs, or to speak. The person usually sees a form, which is shadowy and indistinct, moving towards them. Sometimes the person feels short of breath, or chest tightness, or a weight on the chest. (from Hinton, Hufford & Kirmayer, 2005, p. 6)

Sleep paralysis experiences are as likely in Western cultures as in others. They are seldom disclosed to others for fear that the individual who had such an experience will be thought mad (Hufford, 2005). They are almost always interpreted as involving the presence of demons, evil forces, witches and the like.

> 'Suddenly I felt something come into the room and stay close to my bed. It remained only a minute or two. I did not recognize it by any ordinary sense, and yet there was a horrible "sensation" connected with it. It stirred something more at the roots of my being than any ordinary perception . . . a very large tearing vital pain spreading chiefly over chest, but within the organism . . . I was conscious of its departure as of its coming; an almost instantaneously swift going through the door, and the horrible "sensation" disappeared.' (from James, 1902, quoted by Hufford, 2005, p. 15)

> J was awakened at about 3.30 am by the sound of the apartment door slamming shut. J knew that this was impossible. She always locks and bolts the door before going to sleep. She was aware of a presence, but was afraid to move her head and look because she was terrified of the repercussions if 'it' knew she was awake. At one point she did manage to peer from one eye and saw a sepia-coloured blob, about four feet high, hovering over the feet of a friend who was sleeping in the apartment. Then 'it' moved towards her and she was conscious of a heavy weight moving from her shoulder to her feet, like a repulsive caress, though not sexual in nature. Then the thing moved back to her friend. After a total period of what seemed like nearly an hour, she was aware that the thing was gone, and J felt able to move. She could see that her friend was still safely asleep. She was unable to fall asleep for the rest of the night. (described in Hufford, 2005)

Sleep paralysis is thought to be non-psychopathological (Hinton et al.). It is, however, experienced as involving malign spiritual forces, even by individuals and within cultures in which such beliefs

are not normative. And it may be interpreted (wrongly) as a sign of psychopathology. Sleep paralysis highlights the difficulties of disentangling cause and effect with respect to spirit beliefs and psychiatric illness, and also offers clear support for the idea that experiences of demons and the like are not psychotic and do not cause psychosis.

Here is an example of a case involving psychiatric illness, in which spirit beliefs are important, though probably not causal. This ethnographic study by Broch (2001) describes a psychiatric breakdown in an Indonesian village, which provided a significant source of 'entertainment' and discussion for several weeks.

Belo was a young married man who returned to his village, wife and family after a mission to seek the purpose of life from a guru in a different area. This had followed his expulsion from the village for aggressive and threatening behaviour, which doctors had not been able to treat. On his return he said that he had been ordered by Allah (Tuhan) to teach the village the right ways of Islam. Although his manner was intense, his speech was calm and clear. He claimed that he could see through people, knowing what they thought. He had a special stone which sparkled when held near a person who understood the purpose of life. He claimed that his deceased uncle (Om) was directing his movements. He also claimed that he could see through objects and into the future, and that he was a prophet. He threatened and beat up 'bad' children and destroyed banana plants, and the villagers were worried about future disasters. There was an enormous amount of debate and discussion about what to do about Belo – expulsion, hospitalisation (too expensive) – or what? It was agreed that a hen should be sacrificed to appease a red-haired Jin who had met Belo in the forest. Belo's actions were being controlled by this Jin, not by Tuhan, or by Om, as Belo claimed. He was given herbal treatment, and the hen was sacrificed. Over the years Belo suffered intermittent attacks of craziness, and was sometimes locked up. Broch felt that the villagers accepted that many people go through periods of craziness, for example children when distressed, or young people in love, and that there was always hope that Belo would settle down. (described in Broch, 2001)

In this account spiritual forces were seen as important in Belo's illness and in the villagers' attempts to help. Western medical treatment was not used extensively because of its expense, and this throws up an important feature of spiritual treatments – their pragmatic aspects. Treatments such as exorcism are cheap, available and often not stigmatising, and the associated beliefs may be accepted because they are part of the package. Such treatments may even be a cause of rising prestige.

Sister Jeanne des Anges (1605–1665) was possessed by seven devils. At times they ranted and raved through her mouth and shouted blasphemous language. They shook her body and caused cramps, convulsions and vomiting. They also appeared to her in the shape of a fire-breathing dragon or threatening wild monster. At night they attempted to seduce her, causing a false pregnancy. With support from a contemporary mystic, Surin, Sister Jeanne increased her religious duties – prayer, confession, self-examination and also exorcism. The devils were slowly defeated, and she conducted a triumphant pilgrimage, acclaimed by thousands. (described in Lietaer & Corveleyn, 1995)

Ensink & Robertson (1999) said that among African psychiatric inpatients and their families, the most commonly used diagnostic categories were *amafufunyana* (bewitchment causing possession by evil spirits) and *ukuphambana* (madness). As in the other studies mentioned, it was a minority who thought that evil spirits were the cause of their problems, even though most people had tried to get some kind of religious or spiritual help. Of 62 African patients, first admissions to a large South African psychiatric hospital, most (61%) had consulted traditional healers. Faith healers were most often consulted, then diviners and finally herbalists. Levels of dissatisfaction with the diviners were high:

'These people are just stripping people of their money, they can't cure.'

'I do not trust them because we used a lot of money and she never got better. They are useless and greedy and only think of themselves.'

'It was said [by the diviner] that he [the patient] was bewitched so that he will be mad for the rest of his life . . .' (quoted by Ensink & Robertson, 1999, pp. 30–2)

Other traditional healers were viewed more positively; for instance, patients were more likely to be satisfied with faith healers.

Patricia was taken to a diviner and given traditional medicines including a purgative . . . but she refused to stay with the diviner or to take the medicine . . . her aunt said that the diviners are all liars, Patricia still ran naked. Later, she went to a faith healer, with whom she stayed for one month. He used prayer and holy water. They say that the *amafufunyana* are all out of her. (described in Ensink & Robertson, 1999)

As in other contemporary studies of help-seeking, psychiatric patients and their families emerge as pragmatic users of available services, apparently doing effective cost-benefit analyses of the services they have tried.

So it looks as though beliefs in evil spirits and bewitchment as causes of madness are not particularly popular, though they are held by a significant minority of people in the cultures that have been studied, including Western cultures. Lipsedge (1996) came to a similar conclusion with regard to the medieval period in England. A careful examination of documents from that period suggests that physical and mental stress were seen as causes of madness, and madness was only very rarely attributed to demons. This is interesting because there is a popular stereotype of medieval views about insanity, namely that insanity was widely believed to be caused by demons. Historically and cross-culturally, belief in possession by demons or evil spirits is a persistent minority view, but it does not ever seem to have been the sole explanation advanced for madness. But experiences of evil presences and forces are terrifying for those possessed or bewitched.

Coker (2004) suggested that in Egyptian society religious belief acts as a personal arbiter in the construction of self. She observed that the religious discourse of Egyptian psychiatric patients creates a meaningful discourse of psychiatric pathology recognisable to others from the same cultural context. Thus, for the Egyptian psychiatrist, religious symbolism does not require interpretation or judgement in itself; it allows the psychiatrist from the same culture to reach conclusions about the patient's condition. Coker suggested that shame is felt in relation to social obligations, not guilt. Guilt, however, is experienced in the relationship with G-d. Thus, for example,

> The concept of guilt may be tied to the notion of receiving (deserved) punishment from G-d. A Muslim man became preoccupied with the idea that he was a devil, and 'responsible for all the sins of society', and therefore deserved to die. He asked his brother to cut him with a razor . . . in his own words, he believed that his parents were not happy with him, which was why G-d was punishing him so severely (and why, in fact, he felt the need to punish himself). (described in Coker, 2004)

Coker's sample was of 913 inpatient files of those diagnosed with a psychotic disorder in a 21-year period, from one Egyptian psychiatric hospital. Of these, 913, 632 (69%) had specific religious content, and of these, 632, 309 (49%) reported religious delusions. Analysis of the religious discourse of the 309 patients reporting religious delusions showed that the most frequently mentioned themes were:

- G-d (mentioned by) 44%
- Curse, black magic 24%
- Controlled by evil spirit 22%
- Devil/s 21%.

Religious 'metaphors' can therefore be an important and culturally appropriate feature of discourse.

We saw earlier some evidence for the suggestion that some people are more prone than others to liminal or mystical experiences, and this suggestion about 'thin-boundaried' individuals may apply with regard to beliefs in and experiences of spirit possession. Houran, Kumar, Thalbourne & Lavertue (2002), in a paper on spirit infestation, found that transliminality related to a variety of beliefs and experiences about bodily sensations and paranormal experiences.

Suppose someone does believe that they have been possessed or bewitched. Might this belief make things worse? Ensink & Robertson certainly thought that this could happen. In their South African interviews with schizophrenics and their families, 'confirmation of witchcraft . . . contributed considerably to further distress':

'He will be mad for the rest of his life. This news troubles us and the elders back home . . . It means that our son is in danger of being killed at any time through traditional medicine. This brings a lot of hurt in our souls and in our minds.' (quoted by Ensink & Robertson, 1999, p. 32)

Margolin & Witztum (1989) described a case involving 'binding', in which we can see that the belief in malign spiritual forces is probably not helping, and might be a causal factor.

Binding is reported to be practised among Christians, Moslems and Jews in North Africa and the Middle East, though it is not regarded with approval by religious authorities in any of these religions. The practice involves making a man impotent, for instance, unable to have relations with any woman other than his wife, or unable to impregnate, or unable to achieve penetration at all. In the Christian world it is generally caused by witchcraft: the supernatural powers of the witch, often in league with the devil, cause the impotence by direct supernatural means. Among Muslims and Jews sorcery is required, often the magical practice of making knots: 'binding'. This practice is carried out for reasons of revenge and hatred. Margolin & Witztum described a Jewish man of North African origin who had a difficult and traumatic relationship with his father. The patient, who was not a religious man but had a traditional religious background, had likely had sexual relations with his wife during the seven days of mourning after his father's death, which is

strongly forbidden according to the Jewish law. That event had caused the patient's impotence through his feelings of guilt. It can also be dynamically explained as a binding castration of the patient by his hated and tyrannical father. The patient felt ashamed of what had happened. He didn't discuss it and didn't believe that he could get any help, because he was 'tied' as punishment by his father. A year later, after the end of the mourning period, the father appeared in the patient's dream and untied him, and three days after the dream the patient's potency came back. (described in Margolin & Witztum, 1989)

This kind of example raises the question whether this patient's problems are a culture-bound syndrome – the beliefs about spiritual forces are so intrinsic to the patient's condition that without these beliefs, the condition might be quite different.

Grisaru, Budowski & Witztum (1997) raise this question with respect to a paper describing possession by *Zar* (spirits). They ask if this is conventional psychopathology or a culture-bound syndrome.

Imebet is an Ethiopian immigrant to Israel with low mood. She had been given some antidepressants, but then frequently needed hospitalisation for severe head and abdominal pains. She said that these pains were caused by failing to receive her *Zar* and carry out his worship rituals appropriately. When she was able to do this, she felt euphoric, wonderful. She entered into a dispute with the immigration and absorption authorities because she required housing which gave her a room to be devoted solely to *Zar* ceremonies. Her children were being cared for in foster day care, since she was (according to the social worker) spending most of her time 'performing devil worship ceremonies and turning her apartment into a temple'. Interviewed by a sympathetic psychiatrist, she was found to be coherent and logical, within the cultural belief system. Her thoughts and behaviour were focused on the *Zar*, and to someone not conversant with the culture these thoughts may have seemed bizarre, or similar to delusions of reference, or control, or paranoia. (described in Grisaru et al., 1997)

The psychiatric team also considered whether Imebet was suffering from obsessive compulsive disorder. Some improvements seemed to follow when the team was felt to be accommodating to Imebet's beliefs system. Grisaru et al. think that this kind of condition is best conceived as a culture-bound syndrome. In the current DSM-IV scheme, Imebet's disorder might be classified as a dissociative trance disorder (American Psychiatric Association, 1994). The beliefs are culturally carried and avoid the stigmatisation of mental illness. In fact, it allows them to enjoy some positive labelling and prestige.

Greenberg & Witztum (2001) and Greenberg & Brom (2001) describe other culture-bound syndromes. One poignant and common syndrome involves black figures pursuing the unfortunate sufferer when he tries to sleep. More than one-third of ultra-orthodox Jewish Israeli men seen for psychiatric evaluation in a ten-year period reported nocturnal hallucinations of this kind. Most of the referrals were seeking a psychiatric evaluation which might allow them to be excused from compulsory military service, but follow-ups suggested that malingering was not a possibility in most cases. The sufferers all had reported histories of learning difficulties, and it was considered that they had felt humiliated in a culture which places great importance on scholarly religious activity among boys and men. The young men, when interviewed, were withdrawn and monosyllabic, with mild or definite subnormality. Greenberg & Brom suggest that these nocturnal hallucinations – frightening figures from daily life or demons – are a culture-specific phenomenon.

So beliefs in demons and malign spiritual forces may not only exacerbate a psychiatric illness, they may be so heavily implicated that the conventional Western diagnostic categories may be unhelpful. To someone with any knowledge of cultural beliefs about *Zar* in North Africa and the Middle East, Imebet's beliefs are not really schizophrenic delusions. But she is not functioning too well either: her marriage has broken up, her children are not being adequately cared for, and she is quite a drain on social and health services. She may be an example of the way in which religious beliefs and practices can be the 'wrong road' in coping with the problems that confront her (Butter & Pargament, 2003). So it would be misguided to argue that she is perfectly well. The suggested culture-specific syndromes may save us the difficulty of deciding whether and when beliefs about spirit possession are symptoms of schizophrenia or of a culture-specific syndrome. But they do raise questions regarding treatment.

What can a clinical worker do about spirit possession and black magic? In practice, as we have seen, many patients who consult orthodox Western psychiatrists have already tried traditional methods of healing, or if not they may be thinking of doing so. It would be misguided to pour scorn on these – this is just what many people fear, that their convictions about the importance of spirituality and spiritual forces will be derided. Margolin & Witztum (1989) made some

enquiries about culturally embedded beliefs regarding 'binding' – in which malign spiritual forces affect a man's potency. They discussed these ideas with their patient, whose potency had been affected. The patient responded with great relief, saying that he felt that he and his problems had now really been understood. Many mental health workers will actively liaise with healers or religious leaders in dealing with conditions that are believed to have been caused by bad spiritual forces (Greenberg & Witztum, 2001). An argument expressed eloquently by Heilman & Witztum (2000) is that religion can be an *idiom of distress*, and by accepting the idiom, the therapist can become a partner in harnessing spirituality or religious means to cope with the distress.

Abner is an ultra-orthodox Jew suffering from severe paranoid schizophrenia, in part complicated by a traumatic beating by police, some years earlier, following a demonstration. Abner believes that an important rabbinic figure has plans to hurt him and is directing evil thoughts and impulses towards him. He also thinks that his neighbours wish to harm him. He is completely submerged in a world of frightening visions and threatening forces. A change of medication was of some help, but the therapists also encouraged him to continue to carry a book of Psalms with him, and to recite Psalms. This practice is widely believed by ultra-orthodox Jews to be protective and helpful. The therapists said, 'It will certainly help.' They felt that this enables Abner to achieve some level of control, and a sense of personal empowerment. (described in Heilman & Witztum, 2000)

Avraham was suffering from post-traumatic stress disorder, haunted by demons and suffering from self-neglect. The repertoire of conventional psychiatric interventions produced no relief. The psychiatrists were at a loss. 'They are trying to hit and bite at me . . . they are dragging me towards a pit!' he shouts in terror. The therapists eventually enlisted the aid of a saintly kabbalist, long deceased. The patient spent the anniversary of the saint's passing at his grave, fasting and weeping and praying for help. Enlisting the aid of the patient's wife, and using hypnosis and guided imagery, the patient called for help from the saintly rabbi when attacked by the demons: 'In the name of Rabbi Hayyim ben Attar, I tell you, go away!' (The patient gradually improved.) (described in Greenberg & Witztum, 2001)

The extent to which the therapists in these examples actively enlisted spiritual help is controversial, but few people would now dispute that a non-derogatory attitude towards the client's beliefs in evil spirits will help the treatment alliance, and enhance trust in the clinician.

Afro-Caribbean schizophrenia?

Now to turn to a further problem in which the themes emerging in this chapter are important: the so-called Afro-Caribbean schizophrenia problem. The problem, or phenomenon, is that there is a high incidence of schizophrenia in the UK and the USA among people of Afro-Caribbean origin, compared with the incidence among other cultural groups *and* compared with the incidence in the West Indies and Africa (Davis, 1975; Littlewood & Lipsedge, 1981a; Ineichen, 1991; Thomas, Stone, Osborn & Thomas, 1993; Comer, 1999).

What could account for this? We could consider two possibilities. First, and most importantly for our focus, that approved or normative (religious) beliefs and behaviours, or a culture-specific syndrome, might be mistaken for schizophrenia. The second possibility is that stress levels for Afro-Caribbeans in the UK and the USA are such that schizophrenic breakdown is more likely (Sugarman & Craufurd, 1994).

Littlewood & Lipsedge (1981a, 1981b, 1989, 1997) have offered a number of important observations. Here is an example.

X was born in the Caribbean about 40 years previously into a conventionally religious family of middle-class aspirations. She attended church from childhood, and like other members of her family, experienced religious hallucinations which were comforting or exhorting. These religious experiences continued throughout her life. She had a number of fundamentalist (or fundamental) Christian beliefs, for example, in hell and damnation, and in divine intervention in the running of the world. When she was about 20, she emigrated to the UK, hoping to train as a nurse or a secretary. She married a fellow West Indian and they had several children. She found a cold welcome in churches there and tried several, without apparently settling in any one denomination. She continued to have religious experiences. Her marriage deteriorated and she was left to look after the children on her own. She and the children lived in a tenement. Sometimes she was unemployed, sometimes she worked in a factory. Socially she was quite isolated. She entered into a series of cohabitations, none of which was very stable, and she felt a conflict between her sexual needs and religious sanctions. Her relationship with her children became more difficult. She no longer attended church or found religious activity helpful.

At about the age of 35, she found that her food was tasting peculiar, there were strange marks on the walls of her house, and she believed that people were watching her. She began to hear threatening voices. She was admitted

to a psychiatric hospital under section 136 of the Mental Health Act. In hospital her mood was suspicious, angry and labile, varying from tears to a sullen refusal to speak. However, she was well-oriented, with no clouding of consciousness. The initial hospital diagnosis was schizophrenia. She was discharged within a few weeks, on medication. Over the years she was readmitted every few months, but depressive features became more prominent. Her beliefs did not change. Between admissions she functioned fairly well and visited the Caribbean with a view to returning to live there, but then decided that she preferred to remain in the UK. (described in Littlewood & Lipsedge, 1981b)

An Afro-Caribbean is defined as a West Indian person of African descent. Afro-Caribbean social history in the UK and the USA is dominated by the horrendous history of slavery. An estimated 10 million people were kidnapped in Africa (Curtin, 1969) during the seventeenth and eighteenth centuries and transported to work in plantations in the Caribbean and the Americas, where colonisation by Europeans had reduced the native Indian populations – by desettlement, genocide and European-imported illnesses. The present Afro-Caribbean groups in Europe and the USA are composed of economic migrants, as well as, in the USA, descendants of people forcibly shipped there. There were attempts by slaveowners and others to encourage Christianity and to destroy African religion, along with any vestiges of social and family structure. Modern Afro-Caribbean religiosity is said to be a blend of Christianity and some surviving African religious practices and values (Chatfield, 1989; Griffith & Bility, 1996). Howard (1987) concluded that post-Second World War Afro-Caribbean migrants to the UK expected a warm welcome from the Christian churches, but in practice met with cold shoulders and so set up their own groups. Most Christian Afro-Caribbeans in the UK and the USA are affiliated with black-led churches. The most popular forms are charismatic and Pentecostal Christianity, and Seventh Day Adventists. Cochrane & Howell (1995) found, among a random community sample of black men in the UK, in the Midlands, that 27% belonged to white-led churches, 52% to Pentecostal churches (mainly black-led), 4% were Rastafarian and 18% were not affiliated. This suggests two things: first, that levels of religious activity among Afro-Caribbeans in the UK may be high, and second, that the high proportion of people belonging to black-led religious groups means that religion is an

important factor in maintaining and developing a distinct culture and cultural identity.

The material offered by Littlewood & Lipsedge is consistent with the idea that the high incidence of schizophrenia among Afro-Caribbeans in the UK could be accounted for by a normal prevalence of 'true' schizophrenia, plus a number of further cases of culture-specific disorder. Among Afro-Caribbeans a high proportion of cases diagnosed as schizophrenic have a 'religious flavour', are of short duration with a relatively good prognosis and are often preceded by a clear precipitating factor in the week before admission.

Loewenthal & Cinnirella (2003) wondered if the occurrence of culture-specific disorder could be the explanation, given that the incidence of schizophrenia among Afro-Caribbeans in the UK is said to be rising. One might expect that with acculturation, the amount of culture-specific disorder might fall. However, given the continued popularity of black-led religious movements, providing a strong focus for social support, identity and cultural activity, there continues to be a strong cultural framework for the perpetuation of the kind of culture-specific disorder suggested by Littlewood & Lipsedge.

Castillo (2003) thought that the symptoms of functional psychosis can be caused by culturally structured spontaneous trances that may be reactions to stress and trauma. He points out that in non-Western cultures (not just Afro-Caribbean culture) transient functional psychoses with complete recovery are ten times more common than in Western culture. Pote & Orrell (2002) found that ethnicity had a strong effect on the way schizophrenia was perceived in Britain. Among Afro-Caribbeans, compared with other ethnic groups, unusual thought content was less likely to be viewed as a symptom of a mental illness. Millet, Sullivan, Schwebel & Myers (1996) found that black Americans were much more likely than whites to see spiritual factors as important in the aetiology and treatment of mental health problems. This all supports the idea that the spiritual beliefs and behaviours supported in Afro-Caribbean culture, as well as being important factors for social support and recovery, may lend themselves to expression in culturally appropriate form, when under stress.

There are other possible factors in explaining 'Afro-Caribbean schizophrenia'. One is that there is a genetic predisposition. There is no evidence to support this view, and Sugarman & Craufurd (1994)

concluded that stress factors are the most likely culprits. This can be coupled with the suggestion that transient episodes of culture-specific disorder are precipitated by stress, and with the likelihood that Afro-Caribbeans, by virtue of their socio-economic and immigrant status, are particularly at risk for adversity.

One more link needs to be added to this argument. The link is already implicitly in place – namely that behaviours, beliefs and symptoms which are culturally carried are likely to be misdiagnosed as schizophrenic. DSM-IV points out that clinicians may have a tendency to over-diagnose schizophrenia in some ethnic groups (see Jenkins, 1998).

Here are three examples. The first is from a horrifically racist account by a white psychiatrist in the early years of the twentieth century of 'dementia praecox in the coloured race'. The second is a case history offered to medical students for diagnosis, and the third is one of several cases involving Rastafarians in the USA, whose religious behaviour is often, in and of itself, taken as symptomatic of psychiatric disorder.

Evarts (1914) described a young Afro-American woman working in domestic service in the USA. She developed a stomach disorder and could not afford an orthodox medical practitioner, so she went to a West Indian herbalist. The herbal treatment was unsuccessful, and the herbalist was reported to have made unwelcome sexual advances. The young woman's behaviour became disturbed and she was sent to her sister's home, but did not calm down: 'She now became very sure that the herb doctor had put a spell on her and she read her Bible constantly to exorcise it. She was admitted to the Washington Asylum Hospital. While there she persisted in her refusal to eat or talk. She now thought that the food was unholy and the people about her unholy. She read her Bible, and prayed all day long.' Evarts continues with further details of this 'patient's' religious activities, suggesting that these were all indicative of 'dementia praecox' (the diagnostic category then used, roughly corresponding to schizophrenia). Evarts makes the chilling comment that the case 'shows very well the primitive character [*sic*] of these people'.

Some of the diagnostic biases apparent in this case history are still noticeable:

A 40-year-old black American professional man, 'Simon', a lawyer, from a Baptist background, had experienced occasional psychic experiences, which he used to discuss with his religious adviser, a man he consulted about major life events and decisions. More recently, Simon has been extremely troubled since a group of colleagues have brought a lawsuit against him. The complaint

is unfounded, but it would be extremely expensive and risky to fight it. Simon took to praying at an altar set up in his living room at home. He discovered that the candles he lit to accompany his prayers dripped wax on to his Bible, and he felt that the words marked by the wax had a special significance. Most people he showed the Bible to were not impressed, but Simon persisted in saying that the marked words had special symbolism, and that he was chosen and marked out for special responsibility by G-d. He also felt that often his thoughts were interrupted by sudden 'thought insertion' from a higher source. (described in Fulford, 1999)

Fulford says that most medical students are likely to suggest a diagnosis of schizophrenia. In fact, once Simon's lawsuit was resolved, his unusual religious practices and beliefs declined. Throughout the episode of the lawsuit, Simon continued to function well, both socially and at work (and indeed there were no other behaviours or symptoms suggesting psychotic illness). Subsequent to the lawsuit, Simon's career continued to develop well and he became very successful.

A 17-year-old Afro-Chinese young man was taken to a Jamaican clinic by his upper-middle-class Afro-Chinese father and his black mother. They complained that their son's behaviour had changed over the previous 18 months. He had become a vegetarian, had stopped eating with his family and was preparing his own meals, grew his hair in dreadlocks, and believed that G-d was a living person (Haile Selassie). The young man said that there was nothing wrong with him, but that his parents did not understand or respect his religious beliefs (Rastafarianism). A mental status examination revealed no abnormalities, and some family therapy sessions reduced the amount of quarrelling, although the parents and son still did not really understand each others' beliefs. (described in Hickling & Griffith, 1994)

These cases highlight our tendency to leap to the conclusion that someone is mad, when we may be watching normative religious behaviour, or a culturally appropriate religious coping behaviour (Loewenthal, 1999).

So the high incidence of Afro-Caribbean 'schizophrenia' may be the result of numbers of cases of transient stress-related disturbance, with culture-specific religiously flavoured symptoms, in principle distinguishable from both type I and type II schizophrenia described earlier. Additionally, there may be some cases – as described above – of people who are not suffering from any form of psychopathology at all, but whose religious behaviour may be construed as

psychopathological. The final section of this chapter will explore the issue of how religious behaviour can affect diagnosis.

Diagnostic issues

How does religious behaviour affect diagnosis? The literature seems to be full of examples of cases of people who are otherwise functioning well, but whose religious behaviour can lead others to conclude that they have gone mad.

If this were the sole issue, we could stop here without labouring this point any further. We could just conclude that there are perfectly harmless and quite sane people, whose behaviour we have to be culturally sensitive about judging.

But in fact there are further issues surrounding this point. First, there are important ethical and legal issues that need to be considered when thinking about group beliefs. Suppose that a religious group encourages and supports beliefs and behaviours that cause members to be dangerous to themselves and to others. Is this a psychiatric problem, or a social issue, or a matter for the police? Second, how can a mental health professional decide whether a piece of religious behaviour is pathological, or normative and harmless? Are there any criteria and guidelines? What are they?

Turning first to the ethical and legal issues, sometimes these seem clear-cut. Some readers will think of the Islamic fundamentalists who hijacked US airliners and flew them into various strategic targets, killing thousands. Some may think of small closed religious groups encouraging individual or group suicide when the group is under threat. Even these examples might be disputed – sympathisers might claim that these are valid forms of political protest when there is a severe threat to a group. But there would still be a sizable vote against allowing and supporting groups known to encourage these kinds of beliefs and behaviours, and, once made, these decisions are for action by law enforcement agencies, not the mental health professions.

But there are less clear-cut cases. Hickling & Griffith (1994) described a number of Rastafarians who had been referred to psychiatric clinics because of group-fostered beliefs and behaviour (see the previous section). Some of the prescribed behaviours are basically harmless (vegetarianism), while others are less obviously harmless and less obviously legal – notably, the use of marijuana. Although

there is growing pressure to legalise the use of cannabis, and indeed it is legal in some countries, it is not legal in the USA, and there are some legal restrictions in the UK. Moreover, there is some medical and scientific concern about health risks. Louisa Nottidge's case, described more fully in chapter 3, is another example where the ethical and legal issues are not very clear-cut – and as with Hickling & Griffith's Rastafarians, psychiatrists were asked to rule that the enthusiastic religious behaviour of a cult adherent was insane, in order to achieve some kind of social control. Schwieso's (1996) account of Louisa's cult involvement made it clear that the Victorian public sympathised with Louisa's parents and family, and felt that Louisa had been duped by an unscrupulous cult leader, who wished to take advantage of Louisa's wealth. The court ruled that she had been wrongly committed into psychiatric care, and that, apart from her eccentric religious beliefs, she was 'safe and harmless', but there was strong public support for the derisory amount of damages awarded to Louisa – a half-penny, which did not buy very much more in nineteenth-century England than it would in twenty-first-century England. Again, the ethical and legal issues have got mixed up with the psychiatric issues, as they did, albeit differently, in the case of Jonathan Martin, the religiously inspired arsonist described more fully in chapter 3. Here Lipsedge concluded that modern psychiatrists would almost certainly reach the same conclusions that the doctors reached in Martin's trial – that he was indeed suffering from a major psychiatric disorder. Lipsedge draws attention to the political and social commentary aspects of Martin's behaviour. But for our purposes, understanding and clarifying religious behaviour to the extent that a diagnostic decision can be made may not allow us to escape the ethical and legal questions that can arise.

Redlener & Scott (1979) described a case of a nine-month-old Afro-American child admitted to hospital with meningitis. The child's mother and grandmother were members of the Holiness church, and prayed ardently for his recovery. The child was permanently handicapped as a result of the illness. The hospital personnel did not think that the mother was fit to care for him and in the ensuing court battle the mother was described as relating to her child in a loving but unrealistic manner: 'she says the child is special to her, she fasts and prays for his recovery, she attributes the illness to demonic forces, and wants to take the child home'. Although these seem reasonably appropriate religiously based ideas, the court accepted that the mother was

'paranoid-schizophrenic', and she was allowed only supervised visits to her child, who was eventually institutionalised.

This may be another example in which a psychiatric diagnosis was used to resolve an ethical-legal issue – in this case a child protection issue. The psychiatric diagnosis does not sound very convincing, and it highlights the way in which psychiatric judgements about religious behaviour can be used to cast real confusion into cases involving safety and protection.

How about the diagnostic issues? Are there criteria and guidelines that can be used to guide mental health professionals? The problems – and a solution – are clearly illustrated in this example.

One Sunday morning when on duty at a London hospital, a psychiatrist was asked by the matron to see a West Indian nursing auxiliary who, after attending her church, had started work on the ward. She had 'become peculiar, singing hymns loudly, neglecting her patients but then, after telling them to have faith in her, had suddenly burst into tears'. Forty-five-year-old Evadne Williams was born in Jamaica and had come to Britain when she was 30, after having worked in the capital, Kingston, as a typist. She had difficulty finding work in London and, disappointed in her wish to become a secretary, worked in a succession of jobs – as a packer, a domestic and a laundress, before eventually finding a permanent niche in the local hospital. She was well liked by her colleagues, black and white, whose only complaint was of her excessive religious zeal, which made them feel rather uncomfortable, particularly when it was directed towards the patients. Nine years after arriving in London, Evadne had joined her local Pentecostal church, which had a mainly West Indian congregation. She remained unmarried and her social life revolved exclusively around religious activities. The highlights of her week were the five meetings of her church, a small independent sect of about 30 members, which met in a rented school hall. Soon after joining she began to 'speak in tongues', one of the 'gifts of the Spirit' encouraged in the sect. She continued working in the hospital, apparently happy, though her only close friends were fellow members of her congregation. Evadne lived alone in a rented room, leaving it only for church or work. In spite of her enthusiasm, she never took any part in running the church or organising activities but could always be relied on as a volunteer for street corner testimony and evangelisation.

Evadne had in fact been admitted briefly to another hospital some months before the psychiatrist in her workplace had been asked to see her. When she saw the psychiatrist at work, she appeared to be in a state of ecstasy. She saw him quite happily, immediately grabbing his arm and making him sit down, but then started sobbing against his shoulder. Then she suddenly gave a scream and rolled over on the floor, crying out something unintelligible. Her

speech had a coherent rhythm, something like that of an evangelical preacher or a racing commentator. Suddenly she jumped up and explained that she was being unfairly treated in the hospital for spreading the word of G-d and that she was being martyred. She asked about the Book of Revelation, started singing gospel hymns and began an ecstatic dance, shouting 'Praise the Lord!' She would not communicate with the psychiatrist. He wondered whether, as she was a Pentecostalist, she had been 'speaking in tongues', and he asked the nurses to telephone the members of her church, who would know what to do. When her friends arrived, they said that this was nothing like speaking in tongues, that Evadne was 'sick in the head' and she had better have an injection immediately. (from Littlewood & Lipsedge, 1989)

Evadne did accept psychiatric help and began to function better. The story of Evadne is a striking lesson for those who believe that understanding of other religions and cultures will be helpful. In this case the psychiatrist had the wisdom to conclude that Evadne's behaviour might not be simply normative glossolalia (speaking in tongues), and the energy to make enquiries with Evadne's co-religionists. This is a strategy recommended by Greenberg & Witztum (2001). The clinician is not in a position to give an authoritative view on whether religious behaviour is pathological or truly pious – but co-religionists or religious leaders may be able to distinguish, and their word is more likely to be accepted by the client.

This, then, is one solution to the problem of resolving diagnostic problems where religious behaviour is concerned. DSM-IV offers support for this advice. Following extensive activity by a Culture and Diagnosis Work Group, clinicians are urged to gain understanding of the beliefs and values of the groups to which their clients belong (Kirmayer, 1998). There are considered warnings and diagnostic criteria. In the case of schizophrenia and related psychotic disorders, these are carefully reviewed by Jenkins (1998). For example, the American Psychiatric Association (1994) warns that it is important to distinguish symptoms of brief psychotic disorder from culturally sanctioned response patterns. In some religious ceremonies, for example, individuals may report hearing voices, but these voices are not normally persistent and are not seen as abnormal by most members of the person's community.

Neeleman & King (1993) surveyed 231 British psychiatrists and reported that most thought that religious leaders should have a recognised and funded role to play in health service delivery. This was regardless of the psychiatrists' own religious views and

practices – only about one-quarter of those surveyed were religiously affiliated, or believed in G-d, but nearly all thought that psychiatrists should consider their patients' religious concerns. Greenberg & Cohen (2003) reported that medical students had difficulties in addressing religious issues in clinical interviews and in making diagnoses, and Neeleman & Persaud (1995) suggested that psychiatrists traditionally feel that religion is an area with which they are not empowered to concern themselves. Thus calling in advice or making referrals to religious leaders or other suitable experts may be something that mental health professionals would be relieved to be able to do.

Further guidance on diagnosis comes from three sources. All have to do with the important question of whether and how the clinician can decide that an individual's religious functioning is in itself healthy or pathological. This raises the issue of placing the boundaries between the functions of the religious and mental health professions, and raises the question of how the mental health professional can avoid the ethically and professionally dubious situation of offering opinions on religious functioning. None of these sets of guidance precludes consultation and cross-referral between mental health and religious professionals.

First, the DSM-IV Religious or Spiritual Problem V-Code (American Psychiatric Association, 1994, discussed by Scott, Garver, Richards & Hathaway, 2003), which allows for the identification of religious problems in their own right, even regardless of other psychopathology. Second, Hathaway's suggestion that Clinically Significant Religious Impairment (CSRI) should be considered along with impairment in other areas of functioning, as a consequence of psychopathology (Hathaway, 2003; Hill & Kalian, 2003; Yarhouse, 2003). Third, Butter & Pargament's (2003) Process Evaluation Model of religious coping offers a helpful perspective for evaluating religious coping strategies. These guidelines are of course applicable in all areas of diagnosis, but they will be reviewed here in the context of this discussion of religious and cultural issues in the diagnosis of schizophrenia.

V-Codes in DSM-IV involve 'other conditions that may be the focus of clinical attention', where the individual either has no mental disorder, or has a disorder that is unrelated to the problem, or where there is related disorder but the problem is sufficiently severe to

warrant independent clinical attention. The Religious or Spiritual Problem V-Code is to be used when a religious or spiritual problem is the focus of clinical attention, for example, the loss or questioning of faith, or problems associated with conversion. Scott et al. point out that there may be:

1. A religious problem with no other psychopathology – as, for instance, an individual who used money set aside for church tithes to pay a deposit on a house. Here there was major worry and guilt over this particular religious issue, but no other signs of clinical impairment.
2. There may be parallel religious and other problems, and these may impact on each other, for example, a young woman who was sexually assaulted and developed both PTSD (post-traumatic stress disorder) and a distressing loss of faith and fall-off in religious activity, which was felt to warrant clinical attention in addition to what she was receiving for PTSD.
3. Finally, there may be religious problems resulting from psychopathology, but these do not require separate clinical attention. For example,

> Savannah is a young single female, with a lifelong active involvement in a Pentecostal church and a strong religious faith. She attended frequently and regularly, helped run youth groups, had many church friends, and spent time daily in prayer and Bible study. Savannah developed recurring intrusive fears of injury or death through contamination, for example, from the HIV virus, or from an accident. She feared that she was exposing herself to harm everywhere she went and she developed rituals of praying for protection every time she left the house or had to touch anything. She stopped going to church and gave up work, because she had to spend so much time praying for protection each time she had to go out that she had no time for church or work, and for the prayer that would be involved in going to church or work. (described in Scott et al., 2003)

In this case Savannah's issues were not primarily religious. Her main concern was with her obsessive rumination. It is possible that the use of the V-Code here would be unnecessary and even counter-productive – the religious problem is an effect of the primary obsessive-compulsive disorder, and it is likely that if the OCD can be helped, Savannah's religious and spiritual impairment may resolve itself.

Hathaway (2003) suggests that in identifying psychopathology, normally only impairment in work and social functioning is considered. He considers that the impact of psychopathology on religious functioning should be routinely considered. Hathaway's proposal is that CSRI (Clinically Significant Religious Impairment) should be identified only where there is other psychological impairment. His suggestion is thus complementary to the introduction of the DSM-IV Religious or Spiritual Problem V-Code (Scott et al.). He suggests not that religious problems should be identified in themselves, but that the clinician should consider the impact of psychopathology on religious functioning, just as clinicians consider impact on social and work functioning. Hill & Kalian (2003) make suggestions about ways in which this might be done, using existing psychometric measures of religious functioning, although fundamental validation work still remains to be done.

There are ethical and professional boundary issues. Larson, Mansell Pattison, Blazer et al. (1986) and Neeleman & King (1993), and many others, have raised the related question of how the clinician's own religiosity might impact on his or her professional practice when considering religious problems and religious impairment. Yarhouse (2003) identifies different ways in which clinicians might regard religion in relation to their clients. For instance, clinicians may see religion as harmful, or as a matter for benign neglect, or as a matter for clinical attention only if religious functioning is impaired – as called for in the use of the DSM-IV V-Code. Or clinicians may attend to clients' religious functioning and values even if not problematic – as suggested by Hathaway in considering CSRI. Yarhouse suggests that this latter approach probably raises the fewest ethical problems.

Butter & Pargament (2003) make the important point that there are no methods of religious coping that in themselves are invariably associated with positive mental health outcomes. Outcomes depend on the *context* of coping, and its integration with the social system. They define three forms of poorly integrated coping:

1. The 'wrong road' – where religious coping is an inappropriate means of coping, for example ignoring a doctor's advice to lose weight after a diagnosis of type-2 diabetes, and instead relying on prayer and faith for a cure. Integrated religious coping would

involve a reliance on prayer and faith, after any appropriate medical advice had been followed.

2. The 'wrong direction' – where religious coping is directed towards poorly integrated ends, for example giving up chances of finishing a professional qualification and abandoning family and social commitments in order to serve G-d by going to a mission abroad. Integrated religious coping would incorporate the idea of serving G-d and perhaps, for example, going (briefly) on a retreat, in order to fulfil one's family, social and work commitments better.
3. 'Against the wind' – poor integration of goals in coping, for example accepting advice that divorce is religiously unadvisable, even with an abusive and cheating spouse. Well-integrated coping might involve accepting that divorce is the most realistic path.

The Process Evaluation Model predicts that both general evaluations of how well adjusted and how well a person is coping, and religious evaluations of how helpful or harmful religion is, will depend on the *integration* of religious coping with the social system. Mental health professionals and clergy were able to distinguish well-integrated from poorly integrated coping, and they did not differ from each other in either their general evaluations of coping, or in their evaluations of religious coping. This is interesting because it suggests that in this area – judgements of coping – the clergy's judgements of general coping are as 'good' as those of mental health professionals, and in the area of religious coping, mental health professional judgements are as 'good' as those of clergy. Of course, other measures might show differences between the judgments of mental health professionals and clergy. But this study does show similarities between the clinical judgements of mental health professionals and clergy in spite of all that has been said and written about their differences of perspective. Of course, this does not mean that mental health professionals are qualified to make professional decisions about religious issues, or that clergy are qualified to make professional decisions about clinical treatment. But it does suggest that both professions have a good sense of when something is wrong psychologically and religiously. Both are equally able to identify the religious 'red flags' described by

Pargament, Zinnbauer, Scott et al. (1998), and tested in the Process Evaluation Model.

A study by Eeles, Lowe & Wellman (2003) involving clinical judgements made by psychiatric nurses of spiritual experiences supported the broad lines of Butter & Pargament's arguments. The nurses' clinical evaluations of spiritual experiences employed a holistic view of the patient, and, as well as taking into account the nature of the experience and its outcomes, took into account the personal and cultural context of the experience.

The essential features of the guidelines that have been proposed for considering religious issues in diagnosis are:

- Obtaining information about patients' religious and cultural values
- Liaison with one or more well-informed people from the same cultural-religious background
- Considering whether religious functioning is in itself problematic
- Considering whether religious functioning has been affected by other psychopathology
- Considering how religion is being used in coping, taking into account contextual factors.

Of course, psychiatric diagnosis is a problematic activity, and we have seen that similar religious beliefs and activities have been variously labelled as schizophrenic, hysterical, manic and harmless. But this chapter has aimed to move in a constructive way through the difficulties of deciding how and when religious behaviour may be genuinely psychotic.

This chapter has examined four ways in which religious issues might be important in schizophrenia. First, are visions, voices and delusions always symptoms of schizophrenia? Provisionally, no, and when they are, their quality may be detectably more unpleasant than the usually benign visions, voices and 'delusions' encouraged, experienced and reported in religious contexts. Can visions, voices and delusions encourage schizophrenic breakdown? Probably not, but there is some rather fragmentary evidence that some religious experiences and practices may be implicated in mood disorders. How about evil spirits and spells, demons and witchcraft? The available evidence suggests that these are not always seen as causes of madness, in any

culture. But in every culture there is a minority who may believe this. Some culture-specific disorders may involve 'possession' and the like, and liaison with appropriate healers, and/or acceptance of the sufferer's beliefs, at least as 'idioms of distress', may be helpful.

The high incidence of Afro-Caribbean schizophrenia in the UK and the USA was examined. It was suggested that the available information is consistent with the idea that schizophrenia may be over-diagnosed, when sometimes clinicians are confronted with a stress-related culture-specific disorder, whose symptoms have a 'religious flavour'. This disorder is relatively transient, having a much better prognosis than schizophrenia. Finally, we turned to the issue of diagnosis. It was conceded that schizophrenia – and other disorders – are sometimes diagnosed when the only 'symptoms' are normative religious behaviour. Some contemporary guidelines for making clinical judgements about religious behaviour were briefly reviewed.

The mental health professions have clearly moved on from a position which was certainly commonly held at one time – that some religious behaviour might be crazy. The transcultural psychiatry 'movement' has succeeded in its demands that other religions and cultures be understood for clinical judgements to be adequate. This could lead to the pitfall that all normative culturally carried religious beliefs and behaviours are regarded as non-pathological. There is growing awareness of this pitfall, with improving sophistication in distinguishing between pathological and non-pathological religious behaviours and beliefs.

3 Manic disorder

Definitions and causes of manic disorder

What are the relations between religion, culture and manic disorders?

The most common mood disorder is unipolar depression, discussed in chapter 4. It affects at least one person in ten at some point in their lifetime. At least one person in a hundred may suffer from bipolar or cyclothymic mood disorder, swinging from high to low moods, sometimes with intervening periods of 'normal' mood, which is neither unduly high nor low. The striking feature of bipolar disorders is mania, characterized by euphoric joy or well-being out of proportion to events and circumstances, plus at least some of the following (Comer, 1999):

- Some irritability and anger, especially if plans are frustrated
- Hyperactivity, seeking social and other activities
- Going without sleep
- Poor judgement, following own grandiose ideas and plans and feeling others are too slow
- Self-esteem which approaches grandiosity
- Flamboyance
- Delusions or hallucinations.

In some forms of bipolar disorder (bipolar II), mania may be mild (hypomania), and in cyclothymic disorder the swings are not extreme, going from hypomania to mild depression. Unipolar mania is not now a recognised clinical or diagnostic category, unlike unipolar depression.

Religious factors and manic disorders

The argument that religion can contribute to psychotic breakdown is advanced by Yorston (2001). He suggests that the neuro-biological changes associated with meditative practices may contribute to a pathway which leads to the onset of mania. Wilson (1997) reached similar conclusions, finding that religion can be a precipitating factor in some affective (mood) disorders.

Ms X was a young woman in her mid-20s with no previous psychiatric history, but who some years previously had experienced two periods of low mood, which resolved without professional intervention. She went on a weekend yoga course encouraging psychological release, and after this she became very restless, sleepless and talkative and telephoned the yoga instructor frequently offering undying love. She went into hospital voluntarily but was detained when she began shouting, embracing some staff and hitting others, and declaring that she had a mission to save the world by offering undying, unconditional love to everyone. Her manic state responded to medication, but it was noted that manic episodes seemed to be preceded by days spent in Zen meditative retreat. Eventually, she refused treatment and entered a Buddhist retreat. (based on Yorston, 2001)

Wilson says that manic surges of elation may be interpreted as religious experiences. He mentions a (bipolar) patient who reported 'five salvation experiences in one day . . . the last one lifted him three feet off the bed' (p. 169). Another patient, a postgraduate student,

had a salvation experience at the beginning of his manic attack. The next day he thought he was the apostle Paul, and the next day he ascended to be G-d. He presented his physician with a cheque for three trillion dollars, signed by G-d, and drawn on the bank of heaven. Treatment with lithium resulted in a reverse descent through the various personalities, finalizing in the resumption of the postgraduate student persona. (Wilson, 1997, p. 169)

The psychiatric and psychological literature reports many cases of possible psychosis in which the religious content is very prominent, and religious beliefs can colour the expression of symptoms. It may seem difficult to distinguish the enthusiastic endorsement of religious beliefs and behaviours which are *collectively* sanctioned by religious groups from a private delusional system. Possibly even trickier is the question whether we can say how the inspirational or prophetic experiences of great religious leaders, or of scientific innovators or creative artists, can be distinguished from delusional

experiences. We would expect that the former would normally lack the key features of manic or bipolar disorder, even though highly enthused. Bartholomew & O'Dea (1998) and Kroll, Bachrach & Carey (2002) argue that religious 'mania' and 'hysteria' are often misconstrued as pathological. The following description is quoted by Bartholomew & O'Dea – an example of group-sanctioned 'devoutness (mis)construed as pathology'.

> Knox reports: 'At one meeting [of the Holy Rollers, during the Kentucky Revivals] not less than a thousand persons fell to the ground apparently without sense or motion . . . Towards the close of this commotion, viz. about 1803, convulsions became prevalent . . . The rolling exercise consisted in doubling the head and feet together, and rolling over and over like a hoop . . . The jerks consisted in violent twitches and contortions of the body in all its parts . . . When attacked by the jerks, the victims of enthusiasm sometimes leapt like frogs, and exhibited every grotesque and hideous contortion of the face and limbs. The barks consisted in getting down on all fours, growling, snapping the teeth and barking like dogs. Sometimes numbers of the people squatted down, and looking in the face of the minister, continued demurely barking at him while he preached to them. These last were particularly gifted in prophecies, trances, dreams, rhapsodies, visions of angels, of heaven, and of the holy city.' (Knox, 1950, quoted in Bartholomew & O'Dea, 1998, p. 4)

Fletcher (1998), describing a meeting of a snake-handling Christian group in Tennessee in the 1990s, said that he was conscious of a joy and sense of cleansing that he was not conscious of in more orthodox Christianity. Even though he personally thought the snake-handling dangerous and bizarre, he found that the individual church members were not unhinged, and derived uplift from their enthusiastic religious participation.

The following case described by Schwieso (1996) further highlights the difficulties of deciding whether behaviour and beliefs are pathological or not.

> A famous mid-nineteenth-century case involved Louisa Nottidge, from a wealthy East Anglian family. Louisa was from a culturally dominant and privileged background, and her story highlights the difficulties involved in religious enthusiasm. She was inspired by a fervent local Anglican curate, whose views became unorthodox. She and others followed him to join his millennarian religious sect, the Agapemone, but her family tracked her down, kidnapped her and had her certified as insane on the grounds that she had 'estranged herself from her mother's house . . . to follow a person . . . whom she believed to be Almighty G-d, and herself immortal'. She was confined to a private asylum whose proprietor asked the Commissioners in Lunacy to examine her.

There were a number of visits and numerous reports on Louisa in the Commission's minutes. The Commission agreed with the certifying doctors that Louisa was suffering from 'religious monomania'. In confinement Louisa was depressed but 'walked up and down singing what she termed praises, making use of no intelligible words'. As time passed, she cheered up and managed to contact the Agapemonites, who mounted a campaign for her release. Release was ordered by the Commissioners in Lunacy, who declared that 'her extraordinary and irrational opinions on religion . . . were irreconcilable . . . with soundness of mind', but that apart from her religious opinions, she was competent, calm and rational. Louisa rejoined the Agapemonites and started proceedings against her family for trespass and false imprisonment. The family's defence counsel sought to expose all the ludicrous, unusual and unconventional aspects of life in the Agapemonite community. Louisa won her case, as the presiding judge told the Lunacy Commissioners that they had no right to confine anyone 'safe and harmless', regardless of their religious opinions. However, popular sympathy was clearly with Louisa's family, and approved of the derisory amount of damages awarded to her. (from Schwieso, 1996)

Although Louisa was considered 'competent, calm and rational', apart from her religious opinions, there were signs of the manic state described for Yorston's patient. But this still leaves open the question whether enthusiasm and excitement, perhaps exacerbated by the stress of being seen as disturbed, and by confinement in a psychiatric institution, might lead to a condition and a diagnosis of mania.

Another nineteenth-century case of 'religious monomania' was Jonathan Martin, described by Lipsedge (2003):

Jonathan was a fundamentalist Christian preacher, outraged by the laxity of the Church of England clergy. He was described as 'always reading his Bible and hymn books, he was entirely under the influence of his dreams: he said they always came true and seemingly he acted upon them', though another acquaintance 'saw no appearance of insanity'. Jonathan, inspired by prophetic dreams, made careful preparations and set fire to York Minster in 1829. One of Jonathan's dreams was described by him: 'I dreamed that one stood by me with a bow and a sheaf of arrows, and he shot one through the Minster door. I said I wanted to try to shoot . . . I also dreamed that a large thick cloud came down over the Minster . . . from these things I thought I was to set fire to the Minster.' At the time, Jonathan's offence was punishable by death, but the jury at his trial returned the verdict that he had set fire to the cathedral while of unsound mind, and he was detained in safe custody. There his custodians reported that he was quiet and inoffensive except when talking about religion. Particularly with reference to the behaviour of ministers of the established church, he quickly 'evinces his disordered Imagination, and that he is labouring under Delusion'.

These cases all point to the difficulty of distinguishing religious excitement and enthusiasm from psychosis in which there is evidence of deterioration in other areas of behaviour and feeling. They certainly show that religiously inspired beliefs can lead to behaviour which is unacceptable to others, and they highlight the difficulty of distinguishing between collectively carried religious beliefs and individual delusional systems, particularly in cases where these beliefs are bizarre and unacceptable to others, and can lead to unacceptable behaviour.

There is a further point of interest in these case histories. The descriptive material is about mania, and with most cases any possible depressive states are alluded to so minimally that the reader cannot be confident that these people experiencing mania are also undergoing phases of depression. Given that unipolar mania is not a currently recognised clinical entity, this is puzzling. We do not know whether this is because any depressive episodes failed to catch attention, or because they were not considered of sufficient interest to be worth recording. There is also the possibility – remote but worth considering – that there may be mania without depression, as suggested by the use in the Nottidge case described above of the term 'religious monomania'.

Monomania is a discarded diagnostic category. It was very popular in the nineteenth century, and may have shaped medical and psychiatric perceptions of disordered individuals, such that manic behaviour was noted while depressive symptoms were disregarded. Bynum (2003) reviews the rise and fall of this diagnostic category: monomania was a category developed by Pinel's eminent pupil Esquirol in *Des Malades Mentales* (1838), and it involves a 'lesion' of *one* mental capacity (for example, the intellect or the emotions) leaving other capacities unharmed. The concept of monomania was overextended to generate terms which are still in use today, such as pyromania and kleptomania. Although the monomanias long ago ceased to be a useful diagnostic category, the occurrence of historical and contemporary descriptions of manic conditions associated with religious practices does raise the question whether mania must always be partnered by depression.

This question cannot be resolved on the current evidence. Bipolar disorders are thought to involve a biological predisposition, and the most likely explanation of the case material is that religious practices

may precipitate manic episodes in some individuals already at risk by virtue of biological predisposition. As we have seen in this chapter and elsewhere, there are many examples of frenzied 'hysterical', dissociative or manic behaviour occurring in groups, but it is unlikely that such group phenomena are exclusive to religious groups.

So there is the suggestion that religious practices may precipitate manic episodes. Although religious factors are not thought to play a role in the actual aetiology of psychotic illnesses, they may play a role in precipitating episodes of illness in people already prone to mood disorders. The suggestion was viewed in the context of the difficulty in deciding whether excited group-sanctioned behaviour (whether religious or other) is necessarily manic or psychopathological. The rise and fall of the concept of monomania was also alluded to: this concept was sometimes used to 'explain' religiously induced episodes of unacceptable behaviour.

4 Depression

Definitions, symptoms, causes and relations with religion

What is depression? And how is it affected by religious and cultural factors?

Five am. The baby and David were both crying. Jonathan got up to see to David. Eva listlessly took the baby and began nursing her. She didn't feel any emotion. What was wrong? Normally, no matter how short of sleep, she would feel a surge of warm love at the little face nestling so close to her. The last few days, maybe longer, she had felt . . . nothing, empty, as if she was holding a strange . . . STOP THINKING LIKE THIS! Pull yourself together! There's nothing the matter with you. There is something the matter with you, but what? It will pass. I'm short of sleep. I'll go back to sleep if the baby will let me, do breakfast, send David to kindergarten, try to clean up the house, feed the baby, get David from kindergarten . . . WHAT'S THE POINT? It just goes on and on, I just feel so useless. What's the matter with me? Why is the sun rising? Who needs another day? Why are people so happy? Why can't I feel happy? Why can't I even sleep? I hate this. I hate it. I hate it. Why doesn't it stop? Why? Why?

Jonathan came back wearily. David was dozing uneasily, and he just hoped that Eva and the baby were both peaceful, so that he could get a few minutes' more sleep before the morning rush. The baby was sleeping peacefully next to Eva, but with a sinking heart Jonathan saw that Eva's shoulders were shaking. She was crying drearily.

'Eva, what *is* it?'

No answer.

'Eva, are you in pain?'

No answer.

'Eva, should you see a doctor?'

No answer.

Jonathan looked at his watch. Nearly six. Well, he'd go to the doctor's surgery and see if there was a doctor there for the early session. Maybe a doctor would come to the house and talk to Eva. This couldn't go on. Eva is not herself. The

house is a mess – even Jonathan could see that and he usually thought that Eva was too keen on keeping him and the rest of the household very organised. Meals were not what they used to be, and Eva herself didn't even pretend to eat. She seemed to sit around listlessly, often crying, had no interest in anything. If Jonathan didn't see to the kids, he was afraid that nothing would be done for them. He was becoming afraid to leave the house, afraid of what might happen without him there. He was not sure how long this had been going on. Looking back, a month ago, everything had seemed fine. Perhaps it was something he had hardly noticed at first. (based on interviews conducted by the author)

Marilyn lived by herself. She had been widowed for many years, and her husband had left her with a comfortable flat and a pension she could manage on, though this was getting a bit more difficult since the pension didn't stretch as far as it used to. Other things had changed, very slowly and gradually. She used to visit friends, and friends popped round. They would go shopping together, or sometimes go to a show. Marilyn's only son had never married, and he lived in South Africa. He telephoned every couple of months or so, but it was a few years since she had seen him. Lately, things had become a bit lonely. Marilyn's close friend and neighbour had become too infirm to care for herself independently, and had moved to sheltered housing. The journey to visit was too difficult for Marilyn. Her only sister and two other close friends had died in the previous few years, so she had no one really close to telephone or visit or go out with. She often didn't feel like shopping, couldn't be bothered. And there was nowhere else to go to, by herself.

She had never been a great reader, and she couldn't concentrate on the TV. She had begun to think about killing herself. Why shouldn't she? No one would miss her. She didn't think it at all likely that G-d would punish her, if He existed at all, but she had not noticed any signs of that. She didn't miss G-d and she didn't think He would miss her. She had read that if you took enough painkillers, it could kill you. The last few times she had gone shopping, she had bought a small pack of 16 painkillers each time. She had more than 200 tablets now. She thought she could swallow them with plenty of water to help them go down. (based on interviews conducted by the author)

Saleh was a young man living in London with his family, and studying. He was born in Egypt. Since childhood he had been an orthodox Muslim, praying regularly. Saleh had a bad relationship with his cousin, Mohammed, who practised magic, even though this was forbidden in Islam. Saleh believed that Mohammed was jealous of him. One day there was an argument between the two. Mohammed cursed Saleh, telling him that he would die. Saleh lost interest in food and drink, and he became very withdrawn and stayed in his room. The doctor was called, and psychiatric advice was sought. He was compulsorily admitted to hospital, where his consultant instituted drip feeding and diagnosed depression, saying that Saleh's belief about being cursed was a delusion. Yet Saleh continued to believe that he had been cursed, and felt very guilty about having upset his cousin. He failed to improve and there

was considerable concern about his life being in danger. His parents called a 'counter-magician' who was able to remove the curse from Saleh. Thereafter Saleh began to eat and drink and his mood improved rapidly. He was discharged two days later. (from Dein, 2003)

George is in his forties, lives in a large city, and is a businessman. Although his home is beautifully maintained and furnished, things are very difficult, he says. They have huge debts, and George's wife has had to go out to work. She earns little, and finds it stressful on top of looking after the house, George and the children, and her workplace colleagues are not all pleasant. George can't really pinpoint a single cause for his difficulties, but he knows that ten years ago he was successful, could treat his family to wonderful holidays, and help out his friends and charitable causes. Then his business began to do less well, his wife had to go out to work and became tired and irritable, and he feels isolated. No one asks him for help, he can't seem to talk peaceably with his family any more, he sleeps and eats poorly, is irritable and morose, and has started to drink quite large amounts of spirits 'which doesn't please my wife'. (based on interviews conducted by the author)

Eva, Marilyn, Saleh and George are depressed. Depression is a very unpleasant illness, sometimes described as being a black tunnel, with no prospect of emerging. The symptoms of clinical depression (major depressive disorder) are:

For at least two weeks, the following **persistent and uncontrollable** symptoms:
a. Low mood
plus
b. At least five of the following:
- Appetite or weight loss or gain (not from dieting)
- Sleep difficulty, or sleeping too much
- Loss of energy
- Moves slowly, or agitated movement
- Loss of pleasure and interest in usual activities (such as social life, sex, work, etc.)
- Inappropriate guilt
- Difficulty in concentration
- Recurrent thoughts of death or suicide.

(Spitzer, Endicott & Robins, 1978)

You and I will probably have experienced most of these feelings, and they are quite normal aspects of the human condition, particularly in response to stress and loss. But mercifully they can often pass, and can often be alleviated by doing things that either need to be done, or are simply enjoyable activities. It is when these feelings persist (for more than two weeks) and cannot be controlled, and are resistant

to distraction and efforts to 'pull oneself together', that a clinical condition is said to be present.

DSM-IV (the diagnostic manual of the American Psychiatric Association) recognises just two broad types of depressive illness – the depressive disorders, sometimes called *unipolar* depression, characterised by the symptoms just described, and the *bipolar* disorders, discussed in chapter 3, in which there are depressed states but also manic phases, in which the sufferer is elated and excessively energetic. Unipolar depression is very common – at least one person in ten is likely to be suffering or to have suffered from it in their lifetime.

Many factors have been shown to cause, or at least to increase the risk of, depression. Very important is the prior occurrence of a life event which has severe threatening implications for the person's preferred lifestyle. Events involving loss are particularly likely to cause depressive illness, especially if the individual is already vulnerable – for example, with poor social support and no one to confide in, or heavy and unremitting caring responsibilities (Brown & Harris, 1978, 1989). Early experience in childhood – such a abuse or early loss – may make individuals more vulnerable to depression, and biological factors may also play a role. For example, women of childbearing age are thought to be more vulnerable to depression than older women, and than men, when all other factors are taken into account (Paykel, 1991). There are many literary examples of people disappointed in love falling into a decline, and in some cultures feuds, envy and disappointment may prompt the use of sorcery, cursing and black magic, often with dangerous consequences, as in the case of Saleh, described at the beginning of this chapter (Dein, 2003). Low levels of the neurotransmitters norepinephrine and serotonin have been linked to unipolar depression (Zaleman, 1995). Cognitive factors – beliefs about the self, ways of interpreting events, expectations about the future – are also thought to be important in the onset and maintenance of depression, for example beliefs that 'I am worthless', 'I was probably to blame', and 'Nothing I do will ever turn out well.'

Knowledge of these cognitive biases are deployed by cognitive behavioural therapists to help change ways of interpreting events and beliefs about the self (Brewin, 1988), and this can help lift depression. Other ways of treating depression include several types of medication, chiefly monoamine oxidase (MAO) inhibitors (for

example, phenelzine/Nardil, moclobemide/Manerix), the tricyclics (for example, imipramine/Tofranil), and the selective serotonin uptake inhibitors (SSRIs) (for example, fluoxetine/Prozac), and the very popular natural 'alternative', St John's wort (Comer, 1999). Other than cognitive behaviour therapy (CBT), already mentioned, other forms of talking therapy – psychoanalytic psychotherapy or counselling – may also be used. Evidence of these other forms' helpfulness for depression is less strong than it is for CBT, largely because of significant disputes about what would constitute suitable evidence. Nevertheless, it is usually concluded that the most effective treatment for depression is a *combination* of medication and talking therapy. Social support can be very helpful – either using existing friendships and relations, or more systematic befriending schemes for those who are socially isolated. Biological factors are thought to be more important in bipolar disorders than in unipolar disorders, and the preferred medication is lithium. Psychotherapy as an adjunct to lithium may help improve functioning in people suffering from bipolar disorders (Comer, 1999).

Does religion play any role in causing or preventing, maintaining or alleviating depression? How might cultural factors complicate the picture? There is by now an enormous scientific literature showing that there is a reliable association between many measures of religiosity and measures of well-being, including lowered distress and depression (for example, Koenig, McCullough & Larson, 2001). Hackney & Saunders (2003) have pointed out that greater specificity is needed in definitions of religion and mental health. Batson, Schoenrade & Ventis (1993), in a systematic review of well-being in relation to orientations to religion, concluded that intrinsic ('sincere') religiosity is generally associated with higher levels of well-being, while extrinsic ('self-focused') religiosity is associated with lower well-being. Pargament (1997) has suggested that particular styles of religious coping are associated with better and worse psychiatric outcomes – in particular, he (2002) concluded that higher well-being is associated with internalised religion, intrinsically motivated religion, and a secure relationship with G-d. Lower well-being is associated with imposed religion, religious beliefs and behaviour that have not been examined, and a tenuous relationship with G-d *and* the world. Many of the studies in this field are correlational, and Levin (1994) asked three crucial questions in his review

'Religion and health: Is there an association, is it valid and is it causal?' He concluded that the answer to the first two questions was probably yes, but in 1994 no firm conclusions could be drawn about the causal relationships. Now, 12 years later (at the time of writing), with some prospective studies being reported, we can be a little more certain about the possibility of a causal relationship. But there remain several open questions. First, many of the studies investigating relations between religion and well-being have not specifically investigated depression. They have used a range of measures of mental health, mental illness and distress. Second, most of the studies have been conducted in predominantly Christian countries, mostly the USA, so we cannot be sure about whether the conclusions reached apply to all cultures. And – probably most importantly – there is much scope for unpicking more precisely the causal pathways involved in mediating between religious beliefs and practices, and states of well-being and distress. We will look particularly at religious coping beliefs.

This section has described and defined depression, has briefly reviewed the main suggestions that have been made about its causes and cures, and has outlined some of the ways in which religion and culture might be implicated. We now focus on two specific issues in the relations between religion, culture and depression: religious coping beliefs, and some gender issues.

Religious coping beliefs

Here are some of the things that bereaved parents said when talking about the death of their child (Gilbert, 1992):

> They say there's reasons for G-d to do everything, you know. I think that's very true because I love him (the second child, born after the death of the first) a lot more now than I would have, had our first son been here.
>
> It was at that time that I really got close to Him through prayer and that, and it was that summer after she died that I surrendered to the ministry.
>
> I realised that I had to change my attitude towards life, that I had to forgive myself, forgive my husband and praise G-d that we were still all alive . . . And I think I turned to G-d then, too.
>
> I got 'It's G-d's will' . . . and I finally laid into one person and I said, 'What possible good could come from making my wife so sick and killing my child?'

And they said, 'Well, you don't always understand the plan.' And I said, 'I'm sorry, but there is no ultimate plan to justify this,' and I said, 'Hitler had a plan.'

Religious factors may have both positive and negative effects on mood, and possibly on mood disorders. Looking at the broad picture, we could identify two possibly important factors – there are more, of course, but let us consider these two for now.

The first set of factors involves those inherent in the **social structures** of religious groups. Religious groups can offer a cohesive social framework, including rules that may actually reduce the likelihood of some of the stresses that increase the risk of depression. Loewenthal, Goldblatt, Gorton et al. (1997a), for example, found that severe stressors such as marital break-ups were both strongly associated with depression, and were less likely in religious groups. Also, acts of kindness are considered meritorious, and nearly all religious groups have good systems for rallying round members who have troubles. Social support is one of the most important factors known to prevent and alleviate depressive illness among those under stress (Brown & Harris, 1978, 1989; Loewenthal, 1995a; Leff, 2001), though it has to be appropriate support, and social support in itself may not always be sufficient.

The second set of factors is **cognitive**. Religious beliefs can be used by individuals in coping with stress. They might be *automatic thoughts*, forming a constant backdrop in the individual's life. Or they might be summoned from a less habitually used, pre-conscious repertoire, or actively sought out from outside sources, and developed to meet the needs of current crisis. Sometimes these beliefs may not be helpful, and sometimes they may be. This section will look at religious coping beliefs and their association with depression, and ask whether and how there might be causal associations.

Pargament, Ensing, Falgout et al. (1990) have made careful study of the features of religious coping beliefs, and how they relate to mental health outcomes after a severe negative life event. These researchers confirmed the importance of various features of coping that are not specifically religious. For example, focusing on the positive, regarding the situation as an opportunity to grow, and having social support were all associated with positive mental health outcomes. They developed a number of scales to assess different

aspects of religious coping, probably the most systematic and rigorous study of religious coping efforts and their outcomes. Pargament et al.'s scales were:

- Spiritually based, e.g. 'Took control over what I could, and gave the rest up to G-d', 'Used my faith to help me decide how to cope with the situation'.
- Good deeds, e.g. 'Attended religious services or participated in religious rituals', 'Led a more loving life'.
- Discontent, e.g. 'Felt angry with or distant from G-d'.
- Pleaded, e.g. 'Asked for a miracle'.
- Religious avoidance, e.g. 'Prayed or read the Bible to keep my mind off my problems'.

Religious aspects of coping that were associated with better mental health outcomes were:

- Beliefs in a just, benevolent G-d
- The experience of G-d as a supportive partner in coping
- Involvement in religious rituals
- Search for support through religion.

Seeing one's troubles as G-d's punishment, however, was associated with poorer mental health outcomes, a finding that has been replicated several times (Koenig, Pargament & Nielsen, 1998; Pargament & Brant, 1998; Pargament, 2002). These beliefs have been described as 'religious red flags'. Pargament, Zinnbauer, Scott et al. (1998) have distinguished between:

- Problems of means – 'wrong road' beliefs, e.g. 'I believe that G-d is punishing me for my sins.'
- Problems of ends – 'wrong direction' beliefs, e.g. 'I have decided to turn away from G-d and live life for myself.'
- Problems of fit – 'against the wind' beliefs, e.g. 'My family and friends speak to me about religion in a way I don't agree with.'

Other studies have also reported on the effects of different religious coping beliefs on mental health. For example, Maton's (1989) useful brief measure predicted well-being after a serious stress – those who felt more strongly supported by G-d and who said that their faith was central to coping were less depressed, and also higher on measures

of well-being and self-esteem, than those for whom religious faith and support were not said to be so important.

Spiritual Support Scale (Maton, 1989)

Next to each of the statements below, indicate how accurately the statement describes your experience, using a number from 1 (not at all accurate) to 5 (completely, always true):

1. I experience G-d's love and caring on a regular basis.
2. I experience a close personal relationship with G-d.
3. Religious faith has not been central to my coping.

Another perspective on religious coping has been offered by Granqvist (2005). Attachment theory as suggested by Bowlby (1969–80) and developed in the succeeding decades offers the idea that individuals are guided in their relations with others by internalised working models, which are based on the early infant-carer relationship. Securely attached individuals differ from those with non-secure attachment histories in their styles of interpersonal relationships, and also (Kirkpatrick, 1999) in their religious histories. Securely attached individuals will develop a pattern of religiosity which corresponds to that of parents (correspondence), while insecurely attached individuals turn to G-d in difficult situations, G-d being used as a compensatory attachment figure (compensation). Granqvist suggests that insecurely attached individuals may involve G-d in coping to a greater extent than securely attached individuals. Granqvist's study involved nearly 200 Swedish participants, and showed that religious coping style was indeed related to attachment history: those individuals who reported non-secure attachment relationships were more likely than those with secure relationships to report:

- A compensatory type of religiosity
- Involving G-d in coping – collaborating with or deferring to G-d rather than being self-directing.

So far, the work described on religious beliefs and coping has been done chiefly in North America and Europe, on people from a Christian background. Do these findings apply in other cultures?

The material is rather limited. One study (Ehsan, under review) was carried out in Iran, with Muslim student participants. Ehsan used the RCOPE religious coping measure developed by Pargament,

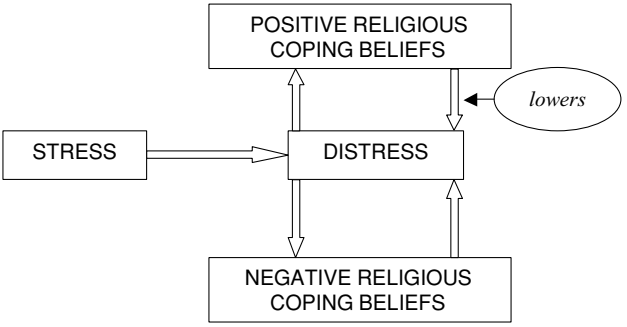

Figure 4.1. Distress stimulates religious coping beliefs, which can then affect levels of distress.

Koenig & Perez (2000) which assesses both positive religious coping, such as benevolent religious reappraisals, and negative religious coping, such as punishing G-d reappraisals. The original Pargament et al. study examined religious coping among college students in the USA as they dealt with a significant negative life event. Better adjustment was related to a number of positive religious coping methods, while poorer adjustment was associated with several negative religious coping methods. In Ehsan's study only the negative religious coping measures related to (poorer) mental health outcomes.

Mental health was assessed by total score on the GHQ (Goldberg, 1978) which includes a measure of depression, as well as anxiety, physical and other symptoms.

At the time of writing, there has been no other published work applying the RCOPE in non-Christian contexts. Ehsan's work is one of the first to look at religious coping among Muslims. His results raise the question whether the lack of positive association between positive coping and positive mental health was the result of the differences in religious-cultural context, or of some other – probably methodological or sampling – factor. Pargament (in a personal communication) suggests that Ehsan's results are likely with a cross-sectional design, which does not tease out two opposing effects – distress stimulates positive religious coping beliefs, and these lead to lowered distress. Thus in cross-sectional research designs, the only surviving effect is the association between negative coping beliefs and poorer mental health outcomes (Figure 4.1).

The effects that Pargament refers to (Figure 4.1) have been partially confirmed in two different religious-cultural contexts, in a two-tiered study reported by Loewenthal, MacLeod, Goldblatt et al. (2000). Although this study did not use the RCOPE, other assessments were made of religious and other coping beliefs. These were:

- A rating of the extent to which this event or difficulty was all for the best.
- Descriptions of why the event or difficulty occurred, from which a rating was made of the extent to which these descriptions reflected a belief that G-d was ultimately in control.
- The extent to which G-d was felt to be close and supportive (assessed using Maton's Spiritual Support scale, described above).
- Descriptions of things that have happened as a result of the event or difficulty. These were rated as good, bad or neither, and the ratio of good/bad consequences described was calculated for each participant.

The study was carried out using Jewish and Protestant participants in the UK, all of whom had suffered a recent or ongoing severe life event or difficulty. Although other work has shown some differences between these two groups in coping beliefs, including, for example, beliefs about the use of alcohol, and beliefs about suicide (Loewenthal, MacLeod, Cook et al., 2003a, 2003b). In this study both groups were similar in the religious coping beliefs studied, and the same causal pathway model was found to apply to both groups. A distinctive feature of this study was that positive affect was assessed separately from depression and anxiety (negative affect), and the effects of the positive religious coping beliefs were stronger on positive mood than they were on distress (Figure 4.2).

Similar effects of positive coping beliefs were found when participants were followed up nine months after their beliefs were first assessed: those with higher levels of positive religious coping beliefs when first interviewed had better mood nine months later. From this study it appeared that stress can stimulate positive religious coping beliefs (as suggested by Pargament, and by McIntosh, 1995), and this effect is mediated by the intrusive, unpleasant thoughts caused by stress. This study confirmed suggestions from other areas of the

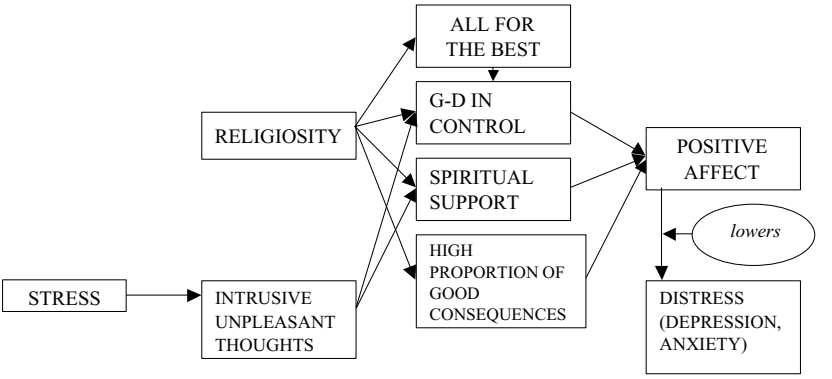

Figure 4.2. Some relations between stress, religious coping beliefs and mood (based on Loewenthal, MacLeod, Cook et al., 2000a).

religion and coping literature, suggested that both positive affect and intrusive thoughts need to be examined when looking at the roles played by religious coping beliefs, and suggested that in the two different cultural-religious groups studied, religious coping beliefs were similar and played similar roles.

A study by Roelofsma (2003) has looked at positive and negative affect in relation to religiosity. As in Loewenthal et al. (2000) the PANAS was used (Positive and Negative Affect Scale, Watson, Clark & Tellegen, 1988.) This was another European study, conducted in the Netherlands, and the participants were a group of charismatic Christians, with a comparison group of students unselected for religiosity. In this study the charismatic Christians were significantly higher on positive affect, with no difference between the two groups in negative affect. The charismatic Christian participants attributed their positive affect to their 'faith, and the relationship with G-d'.

A different kind of study was reported by Dein (2003), who described depression and 'psychogenic death' following interpersonal disputes and cursing. Saleh, described at the beginning of this chapter, strongly believed that he had been cursed, and in his case the belief that the curse had been lifted appeared to be the key factor in his rapid recovery.

Studies of religious coping beliefs have some common problems. Causal relationships are not easily inferred from cross-sectional data. Stronger causal inferences can be made from prospective studies, but

there is a shortage of these, though some have been done. There is a variety of measures of mental health outcomes – even though a number of studies have assessed depression, different measures of depression have been used. And very commonly, pure measures of depression have not been used: more general measures of distress, including depression but also anxiety and sometimes other states, are often used. Positive affect, as an outcome, has seldom been assessed separately from depression.

Nevertheless, some provisional conclusions can be suggested, namely that the religiously active are likely to have access to a repertoire of religious coping beliefs, which may be drawn upon when stimulated by the unpleasant thoughts caused by stress. Negative religious coping beliefs (which may be less commonly used than positive beliefs) increase distress, and there is evidence that this is a genuine causal relationship. Positive coping beliefs improve positive mood, and lower distress, and again, there is evidence that this is a genuine causal relationship. This broad picture appears to hold across the religious traditions that have been studied (Christianity in several forms, with some limited work on Islam and Judaism).

Some gender issues: women, religion and depression

It is widely recognised that women are more likely to suffer from depression than are men. But is this always true? This section will briefly describe the explanations that have been offered, and will then turn to examine the evidence that in some cultural-religious groups these gender differences do not exist. What might explain this? Are gender differences in the prevalence of depression the result of culturally and religiously specific factors? Attention will be given to women's roles as wives, mothers and carers, and religious endorsement of this. Are women disempowered and entrapped by their roles? What is known about the relations between childcare, religion and depression? The section will include discussion of gender differences in factors that relate to depression, particularly religion and religious coping, anxiety, guilt, suicide and alcohol use.

Women are more likely to suffer from depression than are men (e.g. Paykel, 1991; Cochrane, 1993). The evidence on this point is quite plentiful: most studies of depression in community samples show that women are about twice as likely as men to suffer from

unipolar depression. Depression is said to exist in all cultures and societies studied (Chen, Rubin & Li, 1995), though some authors have suggested that depression in non-Western countries is more likely to include physical features such as fatigue, weight loss and sleeplessness and less likely to include 'psychological' features such as self-blame and guilt (Manson & Good, 1993; Comer, 1999). We will return to look at the question of cultural variations in somatisation in a later chapter (chapter 6).

A commonly advanced explanation for gender differences in depression is that women are relatively powerless compared with men, and are more likely than men to suffer from the kind of social deprivation and stress which may lead to depression (Brown & Harris, 1978, 1989). Other explanations – all of which have some supporting evidence – include the role of biological factors, particularly hormonal, and the reluctance of men to disclose depressive symptoms, either because this may put employment at risk, or because they may be seen as a sign of weakness.

Women have also been found to rate higher on religiosity than men (Brown, 1987; Francis, 1993; Paloutzian, 1996; Beit-Hallahmi and Argyle, 1997). This is a widely confirmed finding, though most reports have been from Christian cultures. Loewenthal, MacLeod & Cinnirella (2001) reported that among minorities in the UK, only among Christians were women more religiously active than men; among Hindus, Jews and Muslims, men were more active than women.

If women are – at least in some cultures – both more depressed and more religious than men, is there a connection?

We will look at relevant factors that might have to do with these possible gender differences, or lack of them: guilt, shame and anxiety, suicide, alcohol use, women's roles as wives, mothers and carers, and religious endorsement of these. All may play a role in depression.

Looking first at some unpleasant emotions – guilt, shame and anxiety. How are these related to religion, and could they be linked to and mediate relations between gender and depression?

A possible causal pathway could be:

Religion → Guilt, shame and/or anxiety → Depression

If women are more religious than men, could this be linked with the higher prevalence of depression among women than among men?

Could this be because religious factors somehow make people more anxious, guilty or ashamed?

Anxiety itself has been reported as having rather mixed relations with religiosity (see chapter 4). The higher neuroticism of religious people has been shown to be an artefact of gender: women are higher on neuroticism than are men, and are also higher on religiosity (Francis, 1993). The idea that women are higher on neuroticism than men *as a result of religious factors* has not been seriously suggested in interpretations of these data. Other work on anxiety and religiosity has (as mentioned) suggested rather mixed relations with religiosity, probably the result of conflicting effects, particularly that people in anxiety-provoking situations may turn to religion, and religious coping can be an effective buffer against anxiety states. Work on scrupulosity suggests that scrupulosity about religious practices is fostered in many religious traditions, and although religion does not in itself cause clinical levels of obsessionality, obsessionality is related to higher levels of religiosity (Lewis, 1998; Greenberg & Witztum, 2001).

Work on guilt and shame suggests that while guilt may be higher among the religiously active – though findings are again mixed (Hood, 1992) – shame is not (Luyten, Corveleyn & Fontaine, 1998). Andrews, Qian & Valentine (2002) have suggested that it is shame rather than guilt which is linked to depression. Maltby (2005) has shown a complex pattern of relationships between different styles of religiosity and different types of guilt. Maltby concludes that intrinsic religiosity may be linked to healthy guilt, while different types of extrinsic religiosity are linked to different types of maladaptive guilt. For example, extrinsic-social religiosity (an orientation to religion which is led by the social rewards of religious activity, friendship, esteem and the like) is associated with guilt over failing to meet moral standards. Maltby's work highlights the complexity of the relationships between styles of religiosity and types of guilt. There were gender differences in the patterning of relationships, but there was no obvious support for the hypothetical causal pathway that religion makes people feel more guilty, women are more religious, and therefore women feel more guilty and therefore more depressed.

Anxiety itself covaries with depression, and the separate causal pathways for each are difficult to disentangle.

Overall there is *nothing* that compellingly suggests that because

- women are more religiously active than men (and they may not be), and
- they may suffer from higher levels of anxiety (not all the evidence is consistent), and
- religion causes anxiety, shame and guilt (no significant evidence for this)

this can account for the higher prevalence of depression in women than in men.

Turning now to other factors, suicide and alcohol use may go some way towards accounting for gender differences in depression, and both suicide and alcohol use are associated with religious factors. The suggested effects are that in religious-cultural groups which do not condone suicide and/or alcohol use, depression can be as prevalent among men as it is among women.

Suicide is more strongly condemned in some religious traditions than in others. Christianity and Hinduism have a more equivocal stance on suicide than Islam and Judaism, though no religious traditions have a very positive attitude (Stack, 1992; Ineichen, 1998; Kamal & Loewenthal, 2002). Suicide rates tend to be lower among the more religious, and among religious groups which condemn suicide more strongly. Although women are more likely to attempt suicide than are men, completed suicide is more likely among men than among women. This could all suggest that there are relatively more depressed men in religious groups, particularly those that strongly condemn suicide, than among the less religiously active and in groups which do not condemn suicide. Depressed men are less likely to kill themselves if they believe suicide is wrong. This effect would only account for rather small numbers of depressed men who have decided to stagger on rather than commit suicide, but the available evidence – both on suicide-related beliefs, and on suicide rates – does give some support for this effect (Loewenthal et al., 2003b).

Alcohol use is a popular way of cheering oneself – more acceptable and permissible in some societies and religious traditions than in others. Figure 4.3 suggests how the key factors might relate, and explains the finding that in groups which do not condone alcohol use and drunkenness, depression among men is more prevalent than

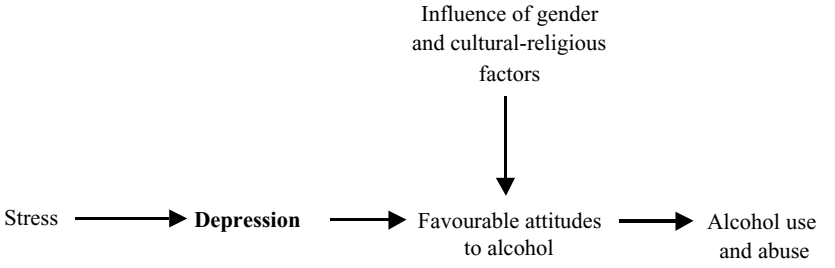

Figure 4.3. The alcohol-depression hypothesis (Loewenthal et al., 2003a).

in groups which condone them – in fact, as prevalent as it is among women.

The evidence is strongest for orthodox-Jewish groups (Levav, Kohn, Dohrenwend et al., 1993; Loewenthal et al., 1995, 2003a, 2003c; Levav, Kohn, Golding & Weismann, 1997). It has also been suggested that similar effects exist among diabetics (Bradley, 2001), and among the Amish (Egeland & Hostetter, 1983), in that both groups abstain from alcohol. There is no suitable evidence available about gender differences in depression among Muslims, whose religious tradition does not support the use of alcohol. What evidence there is on gender, depression and alcohol is partial, but as far as it goes it is quite strong, and the effects are relatively large: depression is *not* more prevalent among women than among men in groups which do not endorse the use of alcohol and drunkenness – and the most likely explanation for this is religious ideology and supported culturally carried beliefs, which make it more likely that depressed men will remain depressed rather than taking to drink.

Turning finally, in this examination of gender differences in depression, and the role of religion – what about religious endorsement of women's traditional roles as wives, mothers and carers, their economic powerlessness, and consequently their vulnerability to exploitation and emotional, sexual and physical abuse?

It has been suggested that an important cause of depression among women is spousal abuse (e.g. Palker-Corell & Marcus, 2004). Religious apologists would vigorously deny that the main religious traditions officially endorse or encourage such abuse, and the very limited empirical evidence suggests that family violence is in fact

lower in households whose members are high on religiosity (Brinkerhoff, Grandin & Lupri, 1992). Many religious traditions – orthodox Judaism and Islam, for example – do endorse and support women undertaking wife, mother and carer roles. The relations between depression and 'burdens of care' are rather complex, but the following points seem to emerge:

- Heavy burdens of care may make women *and* men more vulnerable to depression (Brown & Harris, 1978; Loewenthal et al., 1995).
- However, this effect may be reduced, disappear or even reverse if the religious-cultural tradition endorses and values caring, for example Catholic, Muslim or orthodox Jewish groups which value large families, and/or if there is adequate economic support (Loewenthal et al., 1995).
- Thus religious factors may reduce depressing effects of caring, by placing carers in an esteemed rather than a devalued role.
- Much evidence suggests that high levels of religious involvement are associated with low levels of depression (Koenig, McCullough & Larson, 2001). Apart from the role played by religious factors in coping, an important factor may be lower levels of domestic violence, arguments and divorce, and positive value placed on family lifestyles (Brinkerhoff, Grandin & Lupri, 1992; Loewenthal, Goldblatt, Gorton et al., 1997a) by religious traditions.
- It has often been suggested that religious groups provide good social support, and that this is a factor which helps account for the protective effects of religious group membership. This effect may apply to men as well as to women, and has been described in Muslim and Jewish as well as Christian groups (Maton, 1989; Shams & Jackson, 1993; Lindsey, Frosh, Loewenthal & Spitzer, 2003).

However, sadly, we cannot exclude the likelihood that women may be encouraged to endure unacceptable levels of violence or other abuse, for the sake of maintaining religiously endorsed family life.

This section considered the role played by religious factors in accounting for the greater prevalence of depression among women than among men. It was suggested that rates of depression among men may be raised by religious discouragement of alcohol use and of suicide. Here religious factors may raise rates of depression among

men, but this is by lowering rates of even more unpleasant and dangerous psychopathology. Apart from this, it is unlikely that religion may raise rates of depression in women by making them more anxious, or by increasing powerlessness or vulnerability to domestic violence or other abuse.

It really does appear that religious factors can impact on depression, in direct and indirect ways. Religious coping beliefs have been shown to have an important impact, and as well as studies of Christians, there has been some study of Jews and Muslims. A supportive relationship with a benevolent G-d is associated with better psychiatric outcomes, while religious 'red flags' such as belief in a punishing G-d predict poorer adjustment. Positive coping beliefs are more commonly used than negative ones. Also examined was the question whether religious factors could play a role in accounting for gender differences in depression: there were no clear answers here, but – of the different possible roles played by religion – it was concluded that religion probably plays a beneficial role more often than a malign one. Finally, the material in this chapter, and also in chapter 8, suggests that when relations between happiness, religion and depression are examined, overall, religious factors may promote happiness more often than misery, and – trivial as it may sound – happy people may be less likely to suffer from depression.

5 Anxiety

Definitions, symptoms and causes

Can religious factors reduce anxiety, by offering spiritual or social support and purpose in life, for example? Or do religious beliefs arouse anxiety, by encouraging guilt and worry over failure to carry out obligations?

There is a more specific question: does religion encourage perfectionism as a defence against anxiety? Particularly, does religion cause or exacerbate obsessive or compulsive behaviour or Obsessive Compulsive Disorder (OCD)? This question will be discussed with examples from different religious traditions, particularly from Christianity, Islam and Judaism. These are traditions in which the most clinical and empirical work has been reported, and in which there can be ritual demands which call for a high degree of scrupulosity. Also, is there a possibility that religious people are likely to be perceived as more anxious and obsessional than people who are not religiously active?

Anxiety disorders are based on fear, and they show themselves in a variety of ways. As with other psychiatric conditions, there is "normal" and appropriate anxiety, being fearful or anxious as an appropriate response to a realistic danger, and there is uncontrollable and pathological anxiety, out of proportion to what is realistic.

John had one habit that bothered him, and it bothered his wife Alison, too. Every night he would get into bed, then climb out, go downstairs, walk around the house and check that the back, front and side doors were locked. Even if Alison told him that she was sure the doors were locked, he would want to go and check. Most nights he would drag himself out of bed a second time, and have another check. He felt that it was a bothersome ritual, and he wished that he could control it, but it was never so bad that he felt that he had to consult a doctor or psychologist. (based on interviews conducted by the author)

Ann was a worrier. At every point she would be nervous about possible mishaps and disasters. When her grandchildren came to visit, she would worry that they weren't dressed warmly enough. She would worry that they weren't eating properly. She would worry that they would not get home safely. When she went shopping, she would worry about getting cheated, about getting things home safely without breakages or spilling. At night she tossed and turned, unable to fall asleep, worrying about the most ridiculous things – had she remembered to telephone about the broken washing machine, would she have enough money to pay for the repair, what would happen if it couldn't be repaired, how would they manage with no washing machine, how could they afford a new one, and even if they could, what would happen if something else broke down and had to be replaced . . . She was a bit of a misery to be with, because she always managed to find something to worry about. It seemed to be impossible for her to lighten up. (based on interviews conducted by the author)

Anxiety disorders can assume a range of forms:

- Panic disorder: attacks of breathlessness, dizziness, heart palpitations, terror, urge to escape
- Agoraphobia or claustrophobia: terror of open or confined spaces, with or without panic attacks
- Other specific phobias: severe, persistent and unreasonable fears of, for example, spiders, heights
- Social phobia: extreme shyness, inability to mix with and talk to people
- Obsessive-compulsive disorder (OCD): to a disabling extent, compulsively carrying out specific actions such as hand-washing, or specific obsessive thoughts, such as believing that one will die soon and suddenly from a heart attack. John, in the example described above, suffers from a mild form of this.
- Post-traumatic (and acute) stress disorder (PTSD): disturbing dreams and thoughts, sleep disturbances, irritability, anxiety and depression following a severe stress or trauma; the symptoms do not resolve or subside
- Generalised anxiety disorder (GAD): severe and uncontrollable worry, involving intrusive and unpleasant thoughts, and/or free-floating anxiety. Ann, in the example described above, is a sufferer.

There is often a somatic (bodily) component, resulting from arousal of the autonomic nervous system, and this can often cause a vicious spiral of symptoms. The fearful person may become conscious of

trembling and a pounding heart, and become even more frightened that they are perhaps suffering a heart attack, resulting in more violent palpitations, and further fear.

Anxiety disorders are thought to have a biological basis: relatives of a sufferer have an elevated chance of suffering from anxiety themselves, and the likelihood is greater if the relationship is closer (Kendler, Neale, Kessler et al., 1992; Comer, 1999). However, stressful, frightening and terrifying experiences produce anxiety in anyone.

Many varieties of psychological therapy – cognitive therapy, support groups, behaviour therapy (for example, involving desensitisation) and psychodynamic therapy – have been successfully employed with anxiety disorders. Medication can also be effective, most famously diazepam (valium).

Anxiety disorders can be very unpleasant, though seldom life-threatening. They are usually very treatable, though many sufferers do not seek treatment. How do they relate to religion?

The overall anxiety-lowering and anxiety-heightening effects of religion

Can religious factors reduce anxiety, by offering spiritual or social support and purpose in life? Or do religious beliefs arouse anxiety, by encouraging guilt and worry over failure to carry out obligations?

The study of the relations between anxiety and religion was first systematically initiated by H. J. Eysenck. Eysenck & Eysenck (1985) suggested a three-factor theory of personality. One factor was introversion-extraversion, where the extravert is an outward-looking, lively, sociable individual, who likes lively surroundings and frequent change. Introverts prefer quieter surroundings, the company of perhaps just one close friend, or their own thoughts. Another of Eysenck's three factors was neuroticism-stability, where neuroticism reflects emotional lability. A third posited factor was psychoticism. Eysenck originally suggested that higher levels of conditionability were the result of high anxiety (neuroticism) and introversion. The more conditionable person would be more readily trained, more obedient, and this (Eysenck suggested) would be reflected in higher levels of religiosity. If one inspects the Eysenck

measures of neuroticism, they appear to be assessing both anxiety and depression, and they are claimed to be measuring *traits* rather than *states*, so measures of neuroticism are not pure measures of trait *anxiety*, though they are sometimes taken as such (and they are certainly not intended as measures of *state*).

Eysenck's claims about religion and neuroticism and introversion at first appeared to be well supported (Eysenck, 1975, 1976; Eysenck, 1998). However, Francis and his colleagues have convincingly shown that the higher levels of neuroticism shown among religious people are the result of gender differences: women are higher on both neuroticism and religiosity than are men. If the relations between neuroticism and religion are computed separately for men and for women, there are no associations (Francis, 1993; Lewis & Maltby, 1995; Francis & Wilcox, 1996). This casts doubt on Eysenck's notion that religious people will generally tend to be neurotic introverts. Other work on anxiety and religiosity has also suggested rather unclear, weak or nonexistent relations between anxiety and religiosity. This may be the result of conflicting effects, for example that people in anxiety-provoking situations may turn to religion, and religious coping is an effective buffer against anxiety states. Pfeifer & Waelty (1999) found no overall relationship between neuroticism and religiosity in a group of psychiatric patients, nor in a group of healthy controls. There were interesting contrasts between the views of the patients and controls on the relations between anxiety and religion. The patients thought that their anxiety interfered with the practice of religion, while the controls thought that 'religion can make a person sick'.

So, can religious factors reduce anxiety? Cross-sectional, correlational studies may not be able to answer this question because of the possible conflicting effects. And there is a huge range of effects to explore. The list might include:

- The distress-lowering effects of meditation-related practices, physical stillness, posture, mental alertness and the focusing of consciousness (Watts, 2000; Christopher, 2003).
- Some reports from Muslim groups which suggest that Islam may either discourage the reporting of fear, and/or enable effective coping with fear and anxiety (Ingman, Ollendick & Akande, 1999; Abdel-Khalek, 2002; Qureshi, 2006).

- Similarly, Christian beliefs – for example, the Christian concept of grace – have been reported as effective in coping with fears and anxiety (Gangdev, 1998; Alma & Zock, 2001; Brooke-Rogers, 2002; Loewenthal & MacLeod, 2001).
- Religious activity, and religious beliefs, were found to be effective in coping with both depression and anxiety, perhaps more so for anxiety, among both Jews and Protestants (Loewenthal & MacLeod, 2001).
- Traditional Chinese mental medicine involves a holistic approach, one benefit of which may be the 'Tao of a peaceful mind' (Pan, 2003).
- Prayer has been widely alleged and indeed found empirically to be helpful in dealing with fears (Argyle & Beit-Hallahmi, 1975; Maltby, Lewis & Day, 1999; Loewenthal, 2000).
- Social support has often been suggested as being better among religious groups, and this can have a distress-lowering effect, including relief of anxiety (e.g. Shams & Jackson, 1993).

The theoretical and empirical literature on religion and anxiety reduction is patchy, full of promises and conflicting effects, and dominated by the paradox of the ease with which cross-sectional correlational studies can be done, followed by the difficulty of interpreting and of drawing sound conclusions about causal relationships. There are probably two dominant effects, and these effects would mutually cancel each other in cross-sectional studies. Those under stress can become anxious and may start using religious coping strategies. This effect on its own would give a positive association between anxiety and many measures of religion. However, many religious coping strategies have a soothing effect, leading to a negative statistical association between anxiety and many measures of religion.

There may be ways in which religions, and their practices and beliefs, might make people more anxious.

Luyten, Corveleyn & Fontaine's (1998) studies involved nearly a thousand Belgian adults. One focus of their studies was whether religiosity is associated with higher levels of guilt, and whether this might be related to higher levels of anxiety, and indeed to other indices of mental health and distress. Their studies produced fairly clear results, implying that although religious people may have guilt feelings, this is not pathogenic. Shame (shown in other work to be pathogenic) is not related to religiosity. Luyten et al. found that:

- Religiosity was related to guilt.
- Religiosity was unrelated to *any* (other) measures of mental ill-health (anxiety, depression, anger and also shame).
- Religiosity *was* related to a measure of positive mental health, namely empathy.

Luyten et al. thought that it was important to distinguish between two modes of super-ego functioning, guilt and shame. They suggested that their results might indicate that religion is indeed associated with higher levels of guilt, but this does not produce anxiety – though it may produce empathy. They also thought that they had some evidence that, while religion is not associated with higher levels of shame, religion may – for some people – attenuate some of the notoriously maladaptive effects of shame.

Gilbert, Gilbert & Sanghera (2004) explored the importance of shame among South Asian women living in the UK. Family honour (*izzat*) is of great importance. It can be destroyed if, for example, someone marries outside the group, or makes it known that things are not well in the family. The expected feelings of shame may lead to feelings of entrapment, and to fear and depression.

> [Of a wife in an abusive marriage] 'It's a burden on the mind. The more frightened she gets, the more beatings she gets. In being so fearful she will get the work wrong and get more beatings. Her mind will deteriorate as a result, she might become crazy.' (Gilbert et al., 2004, p. 123)

Family honour is important in many cultures. Lee (1999), for example, suggests that it is important in Korean culture. In the past defilement was a source of shame: women and girls captured by the invading Chinese, or men (soldiers) defeated by and in contact with foreign barbarians (US soldiers), were deeply shamed. Many of the shamed soldiers chose death, and women and girls released by the Chinese were refused contact with their families. Taoism has been associated with a shift towards individual educational achievement and material success as the prime source of family honour. When a family member is successful, this is a good omen for the success of the entire family.

These examples show that many kinds of misfortune might be considered a source of shame – for example, being raped or physically abused, suffering military defeat, capture, educational or other failure, marrying outside the group, and even social or physical

contact outside the group. Religious belonging often defines one's social group, and influences the sense of collectivism and the fear of shame. But it is not clear that the 'rules' for what is considered shameful are directly related to religious rules, or that feelings of shame are specifically related to any aspects of religion as such, more than to other kinds of rules. Individuals vary in the extent to which they feel or attribute shame in their interpretations of events and behaviour – but again, there is no evidence on how this might be influenced by religion.

Another religious context in which anxiety and shame are seen to be highly contingent upon religiously encouraged values was described by Greenberg, Stravynski & Bilu (2004). In orthodox Jewish society public lectures and talks on scholarly religious topics are invited from learned men. To be invited is an indication of respect and prestige. Another arena for public performance is in leading public prayers. Greenberg et al. report several cases of social phobias in ultra-orthodox Jewish men in Israel, difficulties particularly related to performance. Fear of the public (*aymat zibur)* has drifted in meaning from the respect the leader of prayers is meant to have for his awesome role to describe performance-related fears. Women are not reported as suffering from these phobias, since modesty is valued in women, and they are not called upon to lead prayers or to speak in public. Women can speak in public as teachers, but there is absolutely no loss of status if a woman shrinks from this role. In our work among strictly orthodox Jews in the UK, however, we did come across women who reported social phobias (Loewenthal et al., 1997b), but these were not seen as significant difficulties, or reasons to seek help, since the women's life-style did not make this a disabling condition. The cases of social phobia and performance anxiety in men described by Greenberg et al. were felt to be motivated by shame, rather than by fear or respect, and there was considerable disability and impact on quality of life.

Benjamin has eight children, is in his late forties, and is respected as a scholar, specialising in the editing of ancient manuscripts. He really wished to teach, but his fear of appearing and speaking in public prevented this. He is terrified that he will blush, and then a chain reaction starts – his voice chokes, his legs tremble, he believes that people are staring at him, and he blushes more deeply. He avoids all situations in which he could be called upon to lead public prayers – such situations are very common for orthodox Jewish men – and he

worries about having to lead prayers in situations he cannot avoid, such as the circumcision of grandsons. He is also unable to use public toilets. He has sought a range of help for his difficulties, hoping that eventually he will be able to overcome his crippling phobia and take up the roles that are expected of him in leading prayer and public speaking. (from Greenberg et al., 2004)

Religious groups may foster lifestyles which can affect overall levels of anxiety. For example, Loewenthal, Goldblatt, Gorton et al. (1997a, 1997b) and Loewenthal, Goldblatt & Lubitsh (1998) analysed traditional Jewish and Christian groups and suggested that such groups with high levels of social concern and care for others may foster mild levels of anxiety, particularly among women, because of the amount of caring responsibility. The same caring networks however may protect against depression.

Work on the relations between religion and guilt, shame and anxiety, may raise some concerns, but there are no clear conclusions confirming causes for concern. We now turn to a more specific issue.

Obsessive-compulsive disorder and religion

Does religion encourage perfectionism as a defence against anxiety? A particularly common concern is whether religion causes or exacerbates obsessive-compulsive behaviour or disorder.

The question was perhaps first popularised by Freud, in one of his first papers on religion and neurosis (Freud, 1907). In this paper he compares religious rituals to obsessive behaviour and concludes that there is very little difference – both have similar dynamics. Both are the result of guilt, which arouses anxiety, which can be relieved by carrying out the ritual/obsessive action. The deeper cause and meaning of the ritual is not usually apparent to the person carrying it out. But there is a key difference: religious rituals are collectively known about, and prescribed for all adherents. Indeed, Freud was to say that religion is a 'universal obsessional neurosis', sparing the individual the task of forming their own neurosis. Freud is *not* actually suggesting that religion causes or exacerbates obsessional behaviour or neurosis – he suggests that religious behaviour is similar to obsessional neurosis, and, furthermore, carrying out religious rituals may actually inhibit the development of individualised, personal obsessional neurosis. Freud described obsessional

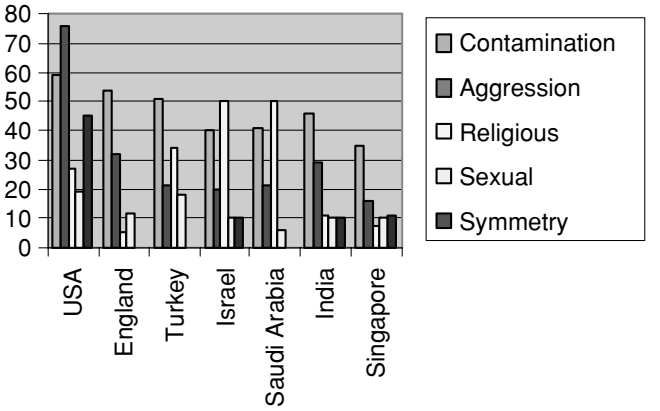

Figure 5.1. Common themes of obsessions in different cultures (% frequency) (based on Tek & Ulug, 2001).

neurosis as the 'pathological counterpart' of the formation of a religion (Freud, 1907); that is, religion itself is *not* necessarily inherently pathological.

These views are at variance with what I think is the more general view of Freud, who is seen having claimed that religion somehow causes neurosis. In this key paper on religion and obsessional neurosis, Freud is not making this claim at all. He is suggesting that religious and obsessional rituals are engendered by similar psychological processes, involving guilt and anxiety, not that religion causes psychopathology.

Still, the idea that religion causes neurosis, by engendering guilt, anxiety and scrupulosity, has haunted the psychological and psychiatric literature. Moreover, religious themes are common themes for obsessions (Greenberg & Witztum, 1994; Abramowitz, Huppert, Cohen et al., 2002).

Contamination and aggression and religious themes are the most commonly reported. Sexual themes and symmetry/exactness are less commonly reported. In Figure 5.1 fear of contamination seems relatively common *and* constant across the different cultures studied, while the two other common themes – aggression and religious – vary widely from culture to culture. Some themes – aggression and sexual, for example – may have religious injunctions underlying them, even though they are not explicitly religious.

So, do religions – particularly those that encourage the careful enactment of prescribed rituals – produce sufferers from obsessive-compulsive disorder (OCD)?

Greenberg, Witztum & Pisante (1987) considered this question, and also whether the scruples encouraged by religion might lead to mistaken diagnosis. They suggested that cases of excessive religious scrupulosity were recognised as excessive, both by sufferers and by their friends, family and religious advisers. For instance:

> Martin Luther is said to have struggled with scruples about his failure to achieve justification (freedom from the penalty of sin). Luther would repeat a confession and to be sure of including everything, would review his entire life until the confessor grew weary and exclaimed: 'Man, G-d is not angry with you, you are angry with G-d. Don't you know that G-d commands you to hope?' (based on Erikson, 1958; Greenberg, Witztum & Pisante, 1987; Bainton, 1990)

> Jonah has become a much more religiously observant Jew over the years. Like other orthodox Jews, his family kitchen has different utensils for cooking and serving milk and meat foods. Unlike other kosher kitchens, the cupboards are stockpiled with stale loaves of bread, opened but disused bottles of tomato ketchup, packets of salt, and other foods that are neither meaty nor milky. Most people will use these neutral, non-milk, non-meat foods with both milk and meat meals, but John becomes frightened after, say, a bottle of ketchup or a loaf of bread has been used at a meal. The children may have touched it with meaty hands. We may not be permitted to use it with milky food. Jonah's rabbi has been consulted frequently, and has tried to convince Jonah, very tactfully, that he is going to unnecessary lengths. Jonah's wife and children felt that they were being driven crazy, and finally they persuaded Jonah to seek some professional advice. (based on Greenberg, 1987; Greenberg & Witztum, 2001)

Greenberg & Witztum have argued that religion provides a means of expression for OCD, but does not cause or exacerbate it. Tek & Ulug's (2001) analysis of Muslim OCD patients in Turkey supports this view. Patients with religious symptoms were not more severely disordered than those without. Unexpectedly, although religious obsessions were common (present in 42% of the sample), they were not more likely among those who were religiously more active. Religious patients were not more severely ill than those who were less religiously active, and they were not more likely to suffer from any particular type of obsession or compulsion. Tek & Ulug concluded that religion is one more arena in which OCD expresses itself, but is

not a determinant of OCD. Similarly, Shooka, Al-Haddad & Raees (1998), in another study of Muslim OCD patients (this study was in Bahrain), concluded that social and religious factors shaped obsessional thought content. And Greenberg & Shefler (2002) found that although a sample of 28 strictly religious Jewish patients suffering from OCD had many more (three times as many) religious symptoms than non-religious symptoms, and most regarded their religious symptoms as their main difficulty, their experiences of religious and non-religious symptoms were similar. There were no differences in age of onset, length of time before seeking help, amount of distress caused, time spent on the symptom, and other factors. This study suggests that religious symptoms were in no way special or protected by OCD sufferers on account of their religious significance, indicating that religious OCD symptoms are no more (or less) entrenched than other symptoms.

So can we accept the conclusion that religion does not cause or exacerbate OCD? Sica, Novara & Sanavio (2002) studied three groups of Italians, high, medium and low in religiosity. The more religious participants scored higher than others on measures of obsessionality, overimportance of thoughts, control of thoughts, perfectionism and responsibility. They suggested that some aspects of religious teachings might be linked to obsessive-compulsive phenomena. In fact, this view accords with Lewis's (1998) conclusion, following a systematic review of the literature, that religion *is* associated with higher levels of obsessional personality traits, but *not* with higher levels of obsessional symptoms; that is, religion may encourage scrupulosity, but not to a pathological extent.

The greater scrupulosity/obsessionality of religious people may be the result of specific religious teachings. For instance, Rassin & Koster (2002) found that religiosity was associated with inflated feelings of responsibility for one's thoughts (thought-action fusion), in a Christian, non-clinical student sample. This compares with Sica et al.'s finding that religious Italians scored more highly than others on measures of overimportance of thought, control of thoughts and responsibility. Cohen & Rozin (2001) found that Protestant Christians – compared with Jews – believed that immoral thoughts (e.g. sexual) were more reprehensible than did Jews. Protestants also believed more strongly that thoughts were controllable, and were more likely to lead to immoral actions. Both Protestants and Jews rated the moral status of actions equally – the differences between the

two religious traditions were the result of differing religious teachings about the reprehensibility of immoral thoughts compared with actions.

All this suggests that religious teachings may indeed affect scrupulosity and ways of thinking, but the evidence indicates that religion does not actually lead to obsessional pathology.

Are religious people *seen* as more anxious?

Lewis (2001) has suggested that there are powerful and persistent stereotypes of the religious.

Is this true?

Gartner et al. (1990) described a study in the USA in which 363 clinical psychologists were asked to make clinical judgements on the basis of case vignettes. Some of the cases were described as religiously or politically active, and such cases were more likely to be judged as suffering from OCD compared with cases with no religious or political activity. In a similar study, Yossifova & Loewenthal (1999) had 96 lay participants read case vignettes of two OCD sufferers, one high on religious activity and one low on religious activity.

Possible confounding factors – such as the gender of the person in the vignette – were balanced. Obsessionality and psychological symptoms were seen as significantly more likely in the OCD sufferer with a high level of religious activity compared with the OCD sufferer with a low level of religious activity, though sadness and tension were not.

The stereotype of the mental health of the religious – as it has been examined in the UK and in the USA – is not uniformly negative. Lewis (2001) asked Northern Irish undergraduate students to complete self-report measures of religious attitude and mental health under four counter-balanced conditions: 'control' (present yourself 'as you really are') and as how 'religious', 'non-religious' and 'mentally ill' respondents might be thought to answer. The 'religious' condition provided significantly higher scores for both the Obsessional Symptom Scale and the Obsessional Personality Trait Scale, but significantly lower Psychoticism Scale scores than the 'non-religious' condition. These results suggest that the religious are viewed paradoxically as having both aspects of better (i.e. lower psychoticism scores) and poorer mental health (i.e. higher obsessional scores) than the non-religious.

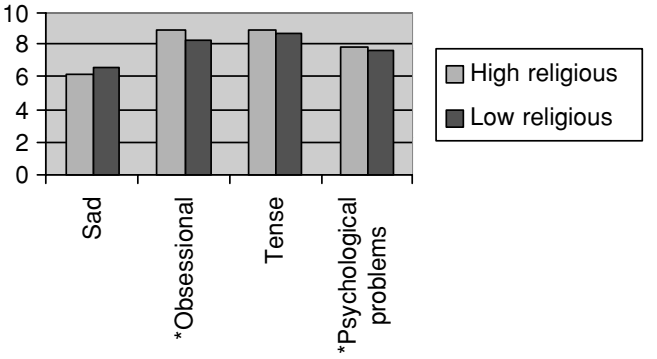

Figure 5.2. Clinical judgements made about people high and low in religious activity (* indicates statistically significant differences) (based on Yossifova & Loewenthal, 1999).

These pieces of evidence suggest the possibility of widespread judgment biases about the mental health of religious individuals. Certainly, in the UK and in the USA, the religiously active are more likely to be seen as suffering from obsessional disorders. The epidemiological evidence is not sufficient to say whether this bias has any foundation in fact.

So, what can we conclude about religion, culture and anxiety? Perhaps the following:

1. Some religious beliefs and practices may have reliable calming effects.
2. Shame has potentially serious implications for psychopathology, and is an important factor in some religious-cultural groups. However, there is insufficient knowledge about whether and how religion is related to shame and the factors that cause it.
3. Religion can encourage guilt and scrupulosity, but this does not produce pathological levels of anxiety or other disturbance.
4. There are stereotypes of religious people which may influence the way in which their behaviour is interpreted by mental health professionals and others. Notably, they are more likely to be judged as suffering from psychological problems and obsessional illness than those who are not known to be religiously active.

6 Somatisation

Definitions, symptoms and causes

Different cultural and religious groups may vary in the extent and in the ways in which they express distress somatically (physically) or psychologically. Do these variations really exist, and how have they been explained?

Mrs A has had a hard life bringing up three children on her own, after her husband was killed in an accident at work. She put in long hours as a domestic worker to try to make ends meet. Lately she has been plagued by severe lower back pain. She has been to see her doctor many times, who has prescribed painkillers and referred her to the hospital for investigations. Physiotherapy has been tried. She would like to have surgery, since she knows people who have been helped by this. However, the specialist says that surgery is not indicated. Indeed, no detectable cause has been found for her back pain, which unfortunately has not responded to any of the medical treatments so far. (based on interviews conducted by the author)

During the Khmer Rouge period in Cambodia, Sac was working at carrying dirt while helping to build a dam. She suddenly felt very dizzy and fell to the ground. While prone, she could see the people around her, but could not speak or move. The episode was treated by the people around her as *Kyol Goeu* – a potentially fatal fainting fit caused by 'wind overload'. She revived and felt better. The episodes did not recur until some years later, when living in the USA, she suffered several attacks after a family crisis. (based on Hinton, Um & Ba, 2001)

Nt was born in Toraja, Indonesia. As a boy, he was said to behave in a wild way, upsetting his parents so much that he was sent away to a remote region to herd buffalo for several years. On his return, his parents continued to be displeased with him – he ran off with girls his parents disapproved of. Eventually, he sailed to a remote province to make his fortune, but war conditions resulted in near-starvation. Nt and his friends suffered terribly. He returned home and married a woman his parents approved of. Unfortunately he could not

conceive a child, and he also became breathless (asthmatic) and suffered terrible stomach pains. He fretted that these afflictions were punishments for his wilful behaviour towards his parents when he was young. Sacrificial offerings to appease ancestral spirits brought no relief. (based on Hollan, 2004)

Somatoform disorder is physical illness without an apparent organic cause, that is, a functional disorder.

There is a range of somatoform disorders, notably:

- Somatisation disorder: somatoform disorder marked by numerous recurring physical ailments without an organic basis.
- Conversion disorder (formerly known as hysterical disorder) in which a need or conflict is expressed in often dramatic physical symptoms.
- Pain disorder associated with psychological factors.
- Preoccupation somatoform disorder in which the person is preoccupied with the concern that there is something physically wrong with them (but there is no evidence of any physical disorder).

There is usually no sense in which the sufferer consciously wants or guides their symptoms, and they usually believe that their problems are genuinely medical. It is often suggested that causes are psychosocial (Garralda, 1996; Martin, 1995; Comer, 1999). It is also possible that in some cases there are undiscovered organic causes.

Chapter 3 included discussion of beliefs in spiritual forces as causes of distress, including some bodily disorders, with a particular focus on psychotic illness. Here we will focus on the backaches, stomach aches and other somatic miseries whose primary cause no one seems to know – neither the sufferer, nor their doctor, family or friends, even though in many cases somatic disorders are seen to worsen under stress. In spite of reasonable efforts to diagnose and treat them, they are untreatable using the conventional weapons of orthodox medicine.

Between-group variations in somatic and psychological symptoms

Littlewood & Lipsedge's (1989) *Aliens and Alienists* eloquently argues the idea that there is a derogatory racist stereotype of the formerly

subject colonial peoples – that they are less capable of perceiving feelings within themselves. The clinical literature sometimes implies that Asians (for instance) are more likely to express distress somatically than they are to express psychological symptoms, particularly those of depression. Is this correct? This section gives an overview of the literature, to see whether this racist stereotype might be confusing understanding of any between-group differences in the somatic expression of distress, and also whether somatisation is an *alternative* to psychological distress.

There are three kinds of study to consider here. First, those studies which describe forms of somatisation which may be culture-specific. Second, studies and reviews which estimate prevalence in one cultural setting: estimates from different sources for different cultures may then be compared. Finally, and most usefully for our present question, studies which compare prevalence of given disorders between different cultural groups, using the same basis (diagnostic categories and criteria, and timeframe).

Looking first at forms of somatisation which may be culture-specific, we consider several examples.

Moore, Sager, Keoprasuth et al. (2001) describe their clinical experience with Mien and Lao people from Laos. Many Lao and Mien people sought refuge from Laos in the USA, particularly those who had supported the USA in the Indo-Chinese war. They are culturally and religiously distinct: Laos had a strong tradition of peaceful coexistence of more than 60 culturally and religiously distinct groups. The Lao mainly emigrated to Laos from southern China in the twelfth and thirteenth centuries, live in the lowlands, have a strong Thervadic Buddhist tradition, and are multilingual. The Mien emigrated from central China relatively recently (nineteenth century), subsist in the highlands by a 'slash and burn' type agriculture, and have religious traditions that are mainly animistic. In spite of these cultural and religious differences, Moore et al. reported a similar and very high prevalence of somatic complaints in a sample of Lao and Mien refugees referred for psychiatric treatment in the USA: 95% had chronic pain, 88% had rheumatological diagnoses, and 53% had unexplained pain. Moore et al. emphasise that somatic complaints can contribute to psychopathology. As with other work in this field, it is difficult to disentangle cause and effect, but

Moore et al. support one suspicion about causality, which is that the very hard forced labour done by many of the immigrants may have contributed to the prevalence of low back and joint pain. They suggest that the presentation of pain and rheumatological disorder along with psychopathology indicates the identification of a (Mien) Somatic Complaint Syndrome.

Another culture-specific somatisation disorder is Khmer *Kyol Goeu* ('wind overload'), described by Hinton, Um & Ba (2001). Again, this disorder is described among Asian refugees to the USA, and again, there appears to be a history of severe trauma. Sac's history, described briefly near the beginning of this chapter, involves wind overload. Hinton et al. believe that the disorder is a form of panic attack caused by anxiety about bodily symptoms, resulting in fainting. Cambodians have specific treatments for this disorder. The most popular is 'coining', involving dipping a coin in 'wind oil' and rubbing it along the sufferer's arm or leg – leaving marks on the skin – in order to displace the wind. Hinton, Hinton, Um et al. (2002) describe another culture-specific Khmer syndrome, the 'weak heart' syndrome. The sufferer experiences palpitations and dizziness on very slight provocation, fears that they will die, and believes that their heart is weak. As with wind overload, there are features in common with the Western concept of panic attack. Of 100 consecutive Khmer referrals to a psychiatric clinic, 60% said that they suffered from a 'weak heart'.

San suffered an attack of fainting and dizziness while a teenager in Cambodia, sleeping little and studying hard. The school doctor diagnosed heart weakness. During the hardships of the Pol Pot period, which included severe torture, episodes became more frequent. Now living in the USA and in her mid-forties, San is almost free of syncopal episodes, after a year's medication for anxiety and PTSD, and training to deal with her catastrophic cognitions and trauma associations. (based on Hinton, Hinton, Um et al., 2002)

Trollope-Kumar (2001) describes and discusses leukorrhea, a common condition in the Indian subcontinent. The most salient symptoms are a whitish vaginal discharge in women, or 'semen loss' in men. Treatment by orthodox medicine might involve antibiotic treatment or tubectomy, but symptoms often continue. Ayurvedic physicians would prescribe dietary or herbal treatments. Sufferers often also complain of other symptoms – headaches, backaches,

dizziness and weakness. There may often be social stress. In Ayurvedic conceptions of health and illness, loss of genital secretions, which are purified *dhatu* (precious bodily substance), may result in weakness and death. Trollope-Kumar suggests that leukorrhea is often treated by Western-trained doctors as if a reproductive tract infection were present, when fuller testing might fail to confirm this, and when symptoms persist after antibiotic treatment. She suggests that leukorrhea is a culture-specific idiom of distress, with deep cultural meaning, and is best regarded with this understanding in mind.

In the West unexplained aches and pains may not have well-entrenched cultural meanings, alternate to those of orthodox medicine – or if they do, the meanings may not be as well articulated as those we have just examined, which are backed up by well-articulated 'alternative' medical systems such as Ayurvedic or Traditional Chinese medicine. So the Western sufferer from unexplained backache and stomach ache may have to patch together homemade explanations for his or her pains, in the attempt to find meaning, explanation and help for their difficulties. But does this mean that Westerners are less likely to suffer from somatoform disorders because they lack culturally carried frameworks for diagnosis, explanation and treatment?

So we now turn to the question whether somatoform disorders are more common in some cultural settings than others. Studies which estimate prevalence in one cultural setting are difficult to compare with each other, because of variations in the ways by which people are selected into the study, and in diagnostic categories and criteria. Nevertheless, these studies may tell us something.

In Moore et al.'s study of Mien and Lao psychiatric patients in the USA, 95% had chronic pain, 88% had rheumatological diagnoses, and 53% had unexplained pain. Hinton et al. (2002) studied 100 consecutive Khmer psychiatric outpatients in the USA, of whom 70 were female. Prevalence of anxiety disorders was high: 60% had PTSD, 50% had panic disorder, and 30% had general anxiety disorder. Of those surveyed, 75% said that they currently or previously suffered from the 'weak heart' condition: palpitations, often accompanied by dizziness, breathlessness and fatigue. The condition is characteristically preoccupying and the sufferer fears that they will die from it. Strikingly, 60% currently suffered from this condition and most of these (54/60 – 90%) feared death from this syndrome.

Hinton et al. (2002) reported that 36% of Khmer refugee psychiatric outpatients reported one or more episodes of 'wind overload' – a fainting attack believed to be potentially fatal.

In India a study of 3,600 mothers who had recently given birth, by Bhatia & Cleland (1995), found that about one-third reported symptoms of gynaecological morbidity. Of these, about half (i.e. about one-sixth of the whole sample) reported symptoms of lower reproductive tract infection (RTI) – white or coloured vaginal discharge (leukorrhea). Trollope-Kumar (see above) has suggested that RTI is often not actually present, even though Western-trained doctors will treat for RTI. Leukorrhea is interpreted in Ayurvedic medicine as a dangerous loss of bodily substance.

When Ono, Yoshimura, Yamauchi et al. (2000) studied somatoform symptoms in the Japanese city of Kofu, 41% of those responding to the survey reported one or more unexplained or poorly explained somatic symptoms. The most commonly reported symptoms were (beginning with the most frequent): lower back pain, concern with body odour, headache, abnormal bodily sensations, joint pain and chronic fatigue. There were some gender differences: for example, half the men reported lower back pain, but only 26% of women, whereas 23% of women were concerned with body odour, but only 13% of men. Although there was a low response rate to the survey – less than one-quarter of those sent questionnaires responded and agreed to be interviewed – the sample was a community and not a clinical sample.

These studies, of course, do not compare one culture with another on comparable measures, but they do give us an idea that some kinds of somatoform disorder are more prominent in some cultural groups than are others, for example concern with body odour in Japan, or leukorrhea in the Indian subcontinent, and that somatoform disorders may indeed be culturally embedded idioms of distress, as well as often being products of very severe and bitter life events.

What do we know about the prevalence and characteristics of somatoform disorders in non-Asian groups?

Bass, Peveler & House (2001) draw on a range of sources offering prevalence estimates for somatoform disorders in the UK, for example:

- Persistent pain lasting six months or more: 22% (Manchester primary care sample: Gureje, Von Korff, Simon et al., 1998)
- Chronic fatigue syndrome: 3% (general population sample, point prevalence: Wessely et al., 1997)
- Three or more unexplained persistent somatic symptoms: 8% (primary care sample: Kroenke & Spitzer, 1998).

Also in the UK, Perkins & Moodley (1993) studied 60 consecutive acute admissions as psychiatric inpatients. More than half the sample (56%) said that they did not consider themselves to have psychiatric problems, 15% considered that they had no problems at all, and 40% that said their problems were somatic or social. There were some variations by ethnicity in the way problems were construed. Afro-Caribbeans were more likely than whites to be compulsorily admitted, and to consider that they had no problems at all. Whites were more likely to somatise, or to say that their problems had social origins.

It is difficult to conclude that somatisation is definitely more prevalent in some cultures than in others. These British studies report that unexplained somatic symptoms are prevalent in a culture which has been allegedly less likely to support or foster somatic expressions of distress.

We have seen that there are culture-specific constructions and manifestations of somatisation and of somatoform disorder, as well as variations in sampling and other factors, making comparisons between cultures difficult.

What about those studies which compare prevalence of disorders in the same diagnostic categories between different cultural groups?

Shaw, Creed, Babbs et al. (1996) studied new outpatients of South Asian origin referred to a gastro-intestinal clinic in a general hospital in the north of England in a six-month period. There were 36 such patients, who were compared with 88 white European clinic attenders, and with a subgroup of these, matched for age, gender and diagnosis. A higher proportion of the Asian patients (72% of Asian patients) had a functional gastro-intestinal (GI) diagnosis than European patients (48% of European patients). When the matched groups were compared, the Asian patients had less severe GI symptoms, and only 23% of Asian functional GI patients had a psychiatric

disorder compared with 42% of Europeans. The authors thought that detection, management and referral of somatisation in primary care needs to be improved. But the findings could mean that somatisation in the form of functional gastro-intestinal disorder is more prevalent among South Asians (in the UK) than it is among white Europeans – even if the disorder is milder in the former group.

Another British study (Bhui, Bhugra, Goldberg et al., 2004) compared somatic symptoms in Asian (Punjabi) and white English primary care attenders in London. The sample sizes were much larger than in the Shaw et al. study (206 Punjabis and 173 white English). Contrary to some previous findings, depression was *more* common among the Punjabis than among the English, particularly among women, while significant somatic symptoms were approximately as prevalent among the Punjabis (28%) as among the English (30%). This study certainly fails to support the idea that depression is experienced more rarely by Asians than by Europeans because suffering is expressed somatically.

Gureje et al. (1998) reported a World Health Organisation study of persistent pain. Data were collected from representative samples of primary care patients from 15 centres in Europe, Asia, Africa and the Americas. Persistent pain was defined as pain present most of the time for six months or more in the previous year. Altogether, more than 25,000 consecutive primary care attenders were screened, and 5,439 people were interviewed, in stratified random samples. Here, surely, are good data on whether people in some cultures might express pain psychologically or somatically. Certainly, there were wide variations between centres, but level of persistent pain was consistently correlated with psychological distress, in all the centres studied. The association between pain and disability was present but not consistently across all centres. It was certainly impossible to determine direction of causality in this research, and likely that persistent pain was a cause of anxiety and depression. However, the data do *not* support the idea that somatic pain is an alternative to psychological pain.

Here, for interest, is the rank-ordering of countries in the study with the proportion (%) of patients reporting persistent pain (women were more likely to report persistent pain than were men, in 12 out of 15 centres):

Chile	33
Germany (Berlin)	33
Brazil	31
Turkey	29
France	27
Germany (Mainz)	26
The Netherlands	26
England	21
India	19
USA	17
Italy	13
China	13
Greece	12
Japan	12
Nigeria	6

There is no obvious pattern here. For instance, more prosperous, developed countries do not appear lower down on the list, as one might expect if people from these countries were less prone to somatoform disorders. Indeed, these countries do not appear in any particular position. The three Asian countries included in the study (China, India, Japan) all appear in the *lower* half of the list, belying any expectation that this somatoform disorder might be more prevalent in Asian cultures than in other cultures.

Some of these findings might support the idea that distress may be expressed somatically, perhaps more so in some cultures than in others, and/or that forms of somatisation may vary between cultures. However, the evidence we have seen so far indicates that the somatic expression of distress is not an alternative to psychological distress, but a supplement, and sometimes a cause. We cannot rule out the possible role of physical adversity in causing some somatoform disorders. Somatisation is reported in European culture as well as in Asian cultures, and indeed in all cultures studied. There is great variation between cultures with respect to the form and prevalence of somatic disorders.

It is often alleged that when researchers have no effects to report, they are unlikely to try to publish these non-findings. And even if they tried, journal editors and reviewers would be reluctant to accept

them. In the context of our discussion, this means that if a piece of research fails to show cultural variations in somatic expressions of distress, it might not have been published. Also, there may be judgement biases among clinicians and/or researchers and/or the academic and medical press. This might involve the *expectation* that some groups may be more likely than others to suffer from somatoform disorders. There is, however, no evidence that such a bias exists. The existing evidence does not support the conclusion that there are systematically higher levels of somatisation in Asian – or probably any other group – compared to European groups. However, somatoform disorders are widespread, there is no group known to be free of them, and backaches, stomach aches and medically unexplained pain are relatively common in all societies, with variations in prevalence between groups. Some specific symptoms and syndromes can take distinctive forms patterned by social and cultural factors, and many examples have been published.

Why and how might variations occur?

Explanations of these variations

Why might different groups of people experience, describe and express suffering, or indeed any feelings, differently? The explanations we consider are:

- That there are variations between languages in the way distress is described.
- That there are culturally carried 'idioms of distress' often involving somatic manifestations, and beliefs in spiritual forces.
- That mental illness and emotional distress are more heavily stigmatised (especially in tightly-knit/religious groups) than are somatic symptoms.
- That adversity plays a role in causing not only distress but also bodily dysfunction.

Linguistic

Hollan (2004), in his account of an Indonesian man suffering from chronic stomach pains and breathlessness (Nt, described at the beginning of this chapter), wondered whether these symptoms were

the result of guilt over youthful misdemeanours, which displeased his parents. But, says Hollan:

> He does not have a word for guilt . . . he would say that he has been in error . . . [which] does not imply sinfulness or inherent badness. But it does imply that one has done something worthy of punishment *if* one is caught. Other humans may discover your misbehaviour, but so might the spirits or ancestors, who may then punish you or your family or descendants with countless forms of misfortune . . . many Toraja risk waiting to see whether their behaviour *has* been noticed and punished before changing their ways and making compensatory offerings. (Hollan, 2004, p. 71)

This epitomises the suggestion that many somatic disorders – and perhaps particularly somatic disorders – are channelled by linguistic factors. The crudest form of this suggestion was objected to by Littlewood & Lipsedge (1997). They dismissed the notion that non-Western people had been alleged to suffer from somatic disorders because their language lacked psychological categories in which to frame their misery. Littlewood & Lipsedge were able to dispose of this claim in its crudest, racist form, and we have seen that current evidence does not support it. But reading Hollan's description, we can see that manifestations of illness are socially and linguistically constructed in ways that can differ between different cultures. Hinton et al. (2001) and Hinton et al. (2002) offer further examples. The Khmer 'weak heart' syndrome, which leads to a continual fear of death from palpitations, is argued to be a development in ethnophysiology influenced by the French colonisation of Indo-China and, more drastically, by the horrors of the Pol Pot regime. There are culturally carried, linguistically framed ideas about weakness (*khsaoy*), wind overload (*kyol goeu*), the vulnerability of the heart and specific symbolic meanings of the heart organ, and a pounding and racing heart.

Bodily metaphor plays an important role in shaping the expression of distress, as of course does awareness of the autonomic and other physiological changes that accompany emotion. But the linguistic 'explanation' of somatisation is inadequate in itself. We can see from the examples described by Hollan, and by Hinton et al., that the somatic expression of distress may be best understood by referring to ethnomethodological understanding of how people in a given culture explain illness. We have also seen that somatoform disorders consistently covary with psychological distress and

psychological disorders. We must therefore abandon any idea that (lack of) language categories may somehow *prevent* the experience of psychological distress.

Idioms of distress/culturally shaped beliefs about aetiology

A widely used understanding of somatisation has been as an idiom of distress.

An early use of this term (the first I can find) was by Nichter in a 1981 article in *Culture, Medicine and Psychiatry*, in which he discussed Havik Brahmin women, who have weak social support, with very limited opportunity to seek counsel outside their household. Pain and other somatic symptoms are important idioms through which distress is said to be communicated. Nichter urged an 'idioms of distress' approach to psychiatric evaluation.

The term has since been widely used, and has been carefully considered in Kirmayer & Young's (1998) systematic review. They confirm that somatisation is common in all ethnic groups and societies studied. There are differences between groups in prevalence, and this cannot be accounted for in terms of differential access to health care services. Analysis of illness narratives suggests that somatic symptoms are located in systems of meaning that serve many social and psychological functions. Somatic symptoms may be:

- An index of disease or disorder
- An indication of psychopathology
- A symbolic condensation of intrapsychic conflict
- A culturally coded expression of distress
- A medium for expressing social discontent
- A way for people to reposition themselves within their worlds.

Kirmayer & Young conclude that between-group differences in somatisation indicate a need to regard somatic symptoms as – among other things – idioms of distress.

Other authors who have viewed somatic symptoms as carriers of social meaning and as idioms of distress include Trollope-Kumar (see earlier in this chapter), who has described leukorrhea (genital discharge) in ways that suggest an idiom of distress, calling for attention to the psychological and spiritual dimensions of the condition. Pugh (2003) offers an account of rheumatic

disorders in India's Ayurvedic and Unani medical traditions, and Ono, Yoshimura, Yamauchi et al. (2001) describe a culture-bound syndrome, *taijin kyofusho* (fear of body odour), in Japan. This syndrome was present in about 7% of the sample studied, and sufferers were mainly older women, who may monitor their bodily sensations and worry about them excessively. Hollan (2004) describes the sado-masochistic behaviour of a white middle-class American man in his mid-thirties as an idiom of distress, and enactment of something he does not have words for: 'Body and behaviour may encode the past in a way that the conscious mind cannot or will not.'

If somatisation may be regarded as an idiom of distress, carrying culturally-shaped meanings, can we say more about how it happens and the factors that are associated with it? The 'idiom of distress' view needs to be amplified by considering the roles played by beliefs in spiritual forces, by stigmatisation and by denial of stigmatised conditions, and by stress/adversity and distress.

Several ethnographic studies point to the importance of beliefs in spiritual forces at the root of somatic disorders. Interestingly, Houran, Kumar, Thalbourne & Lavertue (2002) reported that among North American university students reports of malign spiritual experiences – poltergeists, hauntings, spirit infestations and other paranormal experiences – were related to hypochondriacal and somatic tendencies. The direction of causality is ambiguous.

In a dramatic account Margolin & Witztum (1989) describe their treatment of a married man with three children who had emigrated to Israel from Iran:

> He had become impotent several days after the death of his father. He refused psychotherapy and asked for a medicine that would bring back his potency. However, conventional pharmacological and behaviour therapy did not help and he left treatment because he did not believe anything could help him. Later, the patient reported having improved after a dream whose content he would not reveal. The therapists consulted an Iranian colleague who suggested that the patient might believe that he had been 'bound' by his vengeful deceased father as a punishment for failing to observe the religious laws of mourning properly, and who then unbound him in the dream, one year after his (the father's) death (when the prescribed mourning period was finished). (from Margolin & Witztum, 1989)

'Binding' is a practice known to Christians, Muslims and Jews in Iran, involving witchcraft or sorcery, whose effect is to prevent male

Table 6.1 *A treatment plan (from MacLachlan, 1997)*

Adapted from MacLachlan: Mr Lin's treatment plan	
Cause	Treatment
Food poisoning	Medicine
Overwork	Less time working
Spirit of father	Prayer & sacrifice
Infidelity	Recommit to wife
Childlessness	Aphrodisiacs
Foreign food	Eat British food
Bacteria	Antibiotics

fertility. The therapist discussed this possibility tactfully with the patient, who said that he now felt that the therapist understood him.

Beliefs about spiritual forces can, as the above example suggests, be related to the somatic expression of distress. Even though causality is difficult to infer, some clinicians find it helpful to take these beliefs into account. MacLachlan (1997), for example, describes a possible treatment plan for a patient who suggests that his stomach problems are the result of a range of causes – including the spirit of (another) angry deceased father.

Even though the 'idioms of distress' understanding of somatoform disorders has much to recommend it, other factors may also play important roles.

Stigmatisation – the role of denial

Bodily symptoms may be more readily displayed, felt or admitted to than are psychological symptoms for a number of reasons. These include the 'secondary gains' that may be got more readily from somatic than from psychological illness. Such gains include sympathy and care from the family, sick notes from the doctor, and sick pay from the employer or the state – all easier to obtain for physical than for psychological disorders. Then, remedies and 'fix-it' solutions – notably medication – may be easier to think up and offer for somatic symptoms, culturally approved causal explanations may be more readily available, and physical symptoms may be less stigmatised. The sufferer may receive less blame, and bear less responsibility for putting his health in order again. Perkins & Moodley's (1993) study

of psychiatric inpatient admissions in London found that more than half of the sample did not consider themselves to have psychiatric problems, and that particularly among whites 'denial tended to take the form of somatisation, or construction of problems in terms of social difficulties'.

Causality is often difficult to assess, as in the following example.

Jane was admitted to hospital with severe depression following the birth of her second baby. She insisted that her main problem was severe back pain resulting from a difficult delivery. Physiotherapy did not help, and surgery was not indicated. However, the back pain gradually lessened, and as it did, Jane's depression lifted. (based on interviews conducted by the author)

Li, Logan, Yee & Ng (1999) studied 401 Chinese living in London who had screened positive in a test of possible mental health difficulties. There was strong stigma associated with mental health in the London Chinese community, and interviewees tended to see their symptoms as somatic rather than psychiatric. Ono et al.'s (2000) community study in Japan found 41% of the sample reporting medically unexplained somatic symptoms. Although these were strongly associated with neuroticism, none of the sample had sought psychiatric help in any form. Of course, much of this may be explained by the perception that primary health care is for somatic rather than psychological disorders, and health care systems are indeed opaque when it comes to finding help for psychological illness. But there is evidence to suggest that mental illnesses are stigmatised, especially in tightly-knit communities such as those focused on religious grouping (Cinnirella & Loewenthal, 1999; Loewenthal & Brooke-Rogers, 2004). The following comments about asking for help for psychological difficulties were offered by members of different religious-cultural minority groups in London: black Christian, Muslim, Jewish:

'The one thing black people hate is for anybody to find out there is any form of mental illness in their families . . . what they try to do is shut that person away and deal with it by themselves as opposed to going through all the networks and being exposed.' (Cinnirella & Loewenthal, 1999, p. 519)

'If people can identify you as someone being depressed, I think it's going to make it worse because in a way they tend to be rejected.' (Cinnirella & Loewenthal, 1999, p. 519)

'Our people do not go to the doctor [when depressed], in fact they hide it, because they think that if people know about it they will not accept them and

they'll be laughed at and would be completely shut off because there is this prejudice.' (Cinnirella & Loewenthal, 1999, p. 519)

'I wonder what type of families need this? Is it just those who can't cope? I might feel ashamed to ask for such help.' (Loewenthal & Brooke-Rogers, 2004, p. 233)

Fear of stigma could be one of several factors that make it likely that somatic symptoms will be offered, particularly to the primary medical carer, rather than psychological ones.

Psychological factors and stress

Finally, we must consider the relationship of adversity and distress with somatisation. We can see that several causal pathways are possible. Adversity can lead to distress, and sometimes to physical damage. There can be a spiralling of effects, in which distress states may become pathological, and of course distress states can be caused or exacerbated by physical symptoms.

To consider some examples.

Drossman, Lesterman, Nachman et al. (1990) in the USA found that women with a reported history of physical or sexual abuse were more likely to report pelvic pain, multiple somatic symptoms and abdominal pain. In the Moore et al. study (2001) described earlier in this chapter, it was suggested that the very hard forced labour done by the refugees from Laos may have contributed to the prevalence of low back and joint pain.

It is now well established that somatic disorders accompany psychological distress, including anxiety and depression (Gureje et al., 1998; Ono et al., 2000; Bhui et al., 2004; Haug, Mykleton & Dahl, 2004). Gureje et al., in their study of pain in 15 different centres, as well as showing an association between pain and depressive or anxiety disorders, showed relationships between pain and poor general health (in 11 out of 15 centres), and ratings of interference with work and limitations on activity. They point out that the causal situation is not simple, but these data confirm again that medically unexplained somatic symptomatology cannot be an alternative to psychological distress. The data are also consistent with the possibility that adversity may underlie both psychological symptoms and somatic symptoms.

Before leaving this question of the relations between somatic symptoms, adversity and psychological distress, it is important to raise the question of gender effects. Most studies have suggested a higher prevalence of somatoform disorders among women than among men (Gureje et al., 1998; Kroenke & Spitzer, 1998; Ono et al., 2000; Ono et al., 2001; Silverstein, 2002; Bhui et al., 2004; Haug et al., 2004) though this is not always totally consistent. As we have seen in chapters 4 and 5, women are usually more likely to suffer from anxiety and from depression than are men. So this leaves us with some questions.

To simplify and reduce these to two:

1. Is it possible that adversity is at the root of both somatoform disorders and psychological distress?
2. Is adversity more often experienced by women than by men?

Some of the evidence reviewed in this chapter supports the first possibility, though the evidence might be interpreted in other ways. On the second question, there is very limited evidence. Loewenthal, Goldblatt & Lubitsh (1998) reported gender differences in the experiences of some but not all kinds of adversity. Where there were differences, women experienced higher levels of adversity than men. However, this study was of one group only (Jews, in the UK). Most work involving adversity and gender has not looked at the question whether women's lives are generally more adverse than men's.

We can conclude this overview of religion, culture and somatisation by noting that medically unexplained somatic symptoms have been reported in every culture studied. Symptoms include back pain, digestive and sexual disorders, and intransigent pain. The lack of ready translations for English words describing distress (e.g. 'guilt', 'depression') does not seem to have an influence on the expression of distress in bodily rather than psychological form. Rather, somatic disorder is *consistently* associated with psychological distress and disorder in every culture studied, and is usually associated with disability.

However, there are variations between groups in forms of somatisation. It does appear that:

- There are culture-bound idioms of distress, many of them bodily, and often involving beliefs in spiritual forces.

- Prevalence of specific somatic symptoms varies widely across cultures, and is not obviously associated with technological advance, prosperity or access to medical services.
- Although beliefs in spiritual factors can be present in somatoform disorders, and treatment plans which acknowledge these beliefs may be recommended by some clinicians, there is negligible material to suggest that religious factors play a causal role in somatoform disorders.

Several questions deserve further investigation:

- Might clinicians have *expectations* that somatic disorders are more likely in some groups of people than in others?
- What is the role of adversity, including physical hardship, in medically unexplained somatic complaints?
- Might the generally higher prevalence of somatic complaints in women compared with men be the result of higher levels of adversity?

7 Dissociation

Definitions and causes of dissociation and dissociative personality disorder

Trances and possession states are sometimes thought of as dissociative. Are they? Do religious and cultural factors contribute to dissociative states and disorders?

Eric had suffered serious abuse as a child, and in psychotherapy began to reveal different personalities: 'quiet, middle-aged Dwight, the hysterically blind and mute Jeffrey, Michael, an arrogant Jock, the coquettish Tian . . .'. To the therapist's astonishment, a total of 27 personalities were gradually revealed, with Eric shifting personality as many as nine times in a one-hour session. Some of the personalities would not talk to the therapist, whereas others would; some were aware of each other, and some were very reflective and insightful about Eric. (based on Comer, 1999)

DSM-IV says that the essential feature of dissociative disorder is a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment. Disturbances may be sudden or gradual, transient or chronic.

Dissociative disorders include:

- Dissociative amnesia – inability to recall specific events or information. This is said to follow severely stressful events, and the sufferer may be unable to recall the event even though there is no organic basis for the amnesia.
- Dissociative fugue – the individual travels to a different place and assumes a new identity, and is unable to remember his or her past, or their old identity. As with dissociative amnesia, this can follow severely stressful events, and the individual often cannot be traced until they 'come to' in their new surroundings, or are recognised.

- Dissociative identity disorder (DID) (previously called multiple personality disorder or MPD), involving two or more distinct identities or personality states. The average number is 15 for women diagnosed with this disorder, and eight for men. These recurrently take control of the individual's behaviour. There is an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness, and the disturbance is not due to the physiological effects of a substance or to a medical condition. The different subpersonalities may be aware of each other and each other's characters and feelings, and may converse with each other. Sometimes and in some cases they may not.

Amnesia and fugue may remit spontaneously, and if treatment is called for, may respond well. Identity disorders are more difficult to treat successfully. It is worth bearing in mind that there is support for the view that personality can be viewed as a 'community of internal voices' representing traces of previous experience (e.g. Vygotsky, 1926; Stiles, 1997; Osatuke, Humphreys, Glick et al., 2005). In Osatuke et al.'s study, a healthily functioning woman was interviewed, and six different voices/personas were identified, including an objective, thoughtful observer, a mocking persona, and a strong, goal-oriented voice. It may be difficult in some cases to distinguish dissociative identity disorder from healthy adaptive functioning, especially since even in dissociative identity disorder an individual's different voices may be deployed adaptively.

Dissociation may involve less serious *dissociative states*, in which the person is 'carried away', perhaps in a state of excitement or other emotion, apparently forgetful and unaware of commitments and responsibilies.

All the explanations of dissociative disorders have a common theme – the avoidance of severe pain. There is considerable evidence that people suffering from dissociative disorders are more likely than comparison groups of people to have suffered traumatic/abusive experiences. Fugues and amnesias can follow on from horrific events, and dissociative personality disorders are thought to be more likely in people who have suffered abusive experiences in childhood (Reis, 1993).

It has been suggested that dissociative disorders are the result of a psychological defence, *repression*, in which painful memories and

experiences are blocked from conscious access, to defend against overwhelming anxiety (Noll & Turkington, 1994). Explanations of repression involving cognitive-emotional pathways are gaining favour to an increasing extent (Brewin & Andrews, 1998). For example, it has been suggested that memories are tied to particular emotional states (Eich, 1995). In fugues and amnesia, people when calm cannot recall feelings and events associated with high arousal. In multiple personality disorder, sets of memories are tied to different states and 'subpersonalities' (Putnam, 1985). It has also been suggested that even young children may use self-hypnosis to separate themselves mentally from horrifying events (e.g. Bliss, 1980).

We have two questions to concentrate on – what, if any, are the connections between dissociative states and disorders, and religion? And are religiously flavoured trances and possession states dissociative?

Religious factors in relation to dissociative states and tendencies

Dissociation involves alterations in consciousness, in which integrated processing of information is disrupted (Dorahy & Lewis, 2001). Dissociation need not necessarily be pathological. It can be an adaptive response to traumatic stress. For example:

> Ma Swe was arrested and imprisoned by the oppressive political regime. She and her husband had been producing a current affairs magazine, which was considered politically subversive. In an effort to maintain her sanity and a vestige of well-being, Ma Swe succeeded in dissociating herself from the hideous prison surroundings, and concentrated on producing monthly numbers of the magazine 'in her head'. She wrote articles, conducted interviews, edited, arranged page layouts – everything needed was done, mentally. She also memorised all the articles and rehearsed them. During her imprisonment, she put together 11 issues of the magazine before her release. When visited by a travelling British couple in a Buddhist monastery where she had taken refuge after finding that her family home had been destroyed, she appeared as a kind, cultured woman, with no signs of personality disturbance, in spite of her suffering, and her longing to be reunited with her husband. (based on MacLean, 1998)

Ma Swe dissociated from hideous surroundings in a way that seems productive and adaptive. Guided visualisation has been suggested as an appropriate technique for improving well-being and relieving distress and pain (Seaward, 1998; Matthews, Conti & Sireci, 2001; Kennedy, Abbott & Rosenberg, 2005), and this, too, may be seen

as a form of dissociative activity, with potentially beneficial effects. Guided visualisation is often offered in the context of a diet of spiritual exercises such as meditation, and may itself be seen as a spiritual exercise.

Nevertheless, ecstasy and some religious rituals and other practices may entail dissociation. An interesting hypothesis was put forward by Schumaker (1995). Following Price & Snow (1998), he suggests that ritualistic behaviour during religious worship allows participants to enter a dissociative mental state, to 'step outside physical reality and experience faith'. Information presented during such states is more likely to be integrated with conscious awareness and memory content than it would be otherwise. This provides a framework for the regulation of reality, important for continued mental health. When Dorahy & Lewis (2001) conducted a study involving two groups of Roman Catholics, one group of Protestants and one group of Students, all recruited in Northern Ireland, they suggested, therefore, that:

- Religious groups would have higher scores on dissociation, and also religious ritual and attitudes towards Christianity, than would student groups.
- Measures of religiosity would correlate positively with dissociation scores, especially in religious groups.

Although the first prediction was not borne out, the second prediction was borne out in the Catholic sample, though not in the Protestant sample. This is only partial support for the idea that religion fosters dissociative states.

A slightly less inconclusive study, also based on Schumaker's hypothesis about religion and dissociation, was reported by Dorahy, Schumaker, Krishnamurthy & Kumar (1997). This study showed an overall association between religious ritual practice and experiences of dissociation. Participants in this study were 402 Indian and 263 Australian university students. Cultural and gender differences included higher scores on dissociation by

- the Indian compared with the Australian students
- Australian men compared with Australian women.

This study offers slightly stronger evidence of an association between religious practice and experiences of dissociation, using current ideas

involving the suggestion that memories and cognitions may be tied to particular emotional states.

Houran, Irwin & Lange (2001) looked at New Age philosophical beliefs instead of traditional religious belief and practice, using the same measure of dissociation as Dorahy and his colleagues: the Dissociative Experiences Scale. New Age beliefs were assessed along with traditional paranormal beliefs. Houran et al. expected that dissociative experiences would be associated with New Age beliefs, but not with traditional paranormal beliefs – and this expectation was borne out. They note that New Age beliefs were associated with both pathological and non-pathological dissociation, and that psychopathology was associated with New Age beliefs, but not with traditional paranormal beliefs.

Another (non-correlational) study was of glossolalia (speaking in tongues). Grady & Loewenthal (1997) interviewed a non-clinical sample of Australian adults who practised glossolalia, as well as those who had observed it and those who had done neither. Glossolalia is a religiously encouraged state which may involve dissociative features, and which is said – particularly by those who practise it – to be calming and to promote well-being. Those who did not practise it were more likely to see it as involving ecstasy and excitement.

These mainly correlational studies have produced rather inconclusive findings. Although there is weak support for the idea that – at least in some religious cultures and in some religious groups – the more religiously or spiritually active are also more likely to report dissociative experiences, the associations are weak, and not present in every religious and cultural group. Moreover, studies have focused on reported dissociative experience regardless of whether it is benign, adaptive or pathological. We still do not have a very clear picture of non-pathological and adaptive dissociation, and whether it is more likely to happen, or to be deliberately practised, by some kinds of people rather than others. However, there is perhaps enough to suggest that some religious practices may encourage some kinds of dissociation, and this dissociation is not always pathological.

While there is evidence that pathological dissociation is associated with severe stress, and benign dissociation may sometimes have escape from stress as an aim, escape from stress is not always the primary aim of benign dissociative techniques. It may indeed be, as Schumaker suggests, something that is encouraged in some

religious groups in order to facilitate the absorption of beliefs which can have an adaptive function.

Religious factors in relation to dissociative personality disorder

What are the relations between religion and dissociative personality disorder? We shall leave the question of religious trances and possession states until the next section of this chapter, focusing here on cases which are uncontroversially those of dissociative/multiple personality disorder.

Here is an account of dissociative/multiple personality disorder from the perspective of a survivor, in which there are several religious motifs:

> Annie grew up hearing her mother repeat all the things that were wrong with her – she was a girl, when her parents had wanted a boy, her hair was wrong, everything. Annie's mother said that Annie looked like her (the mother) and she hated herself. Annie remembers her mother as unaffectionate and distant, often unresponsive.
>
> As a young child, Annie was abused by her teacher, and when she moved to a different school the abuse continued. Annie would sometimes just wander off, but no one questioned this or saw it as an act of desperation.
>
> At home Annie's parents screamed and argued and threw things. Annie developed severe migraine headaches and was hospitalised. Sometimes everything would just 'fade away', and Annie was oblivious to the sights and sounds around her. She felt safer and protected from pain if she could not see or hear anything. Often she would be in trouble for doing things that she had no recollection of doing. Annie once told her mother that she had voices in her head, and her mother told her to keep quiet about this or she would be locked up. 'I had no answers. The one time I told my mother about other voices in my head she told me that they would lock me up if I ever said anything like that.'
>
> As a teenager, she bullied others in school. At home she cleaned and cared for her younger sister, to placate her mother, but her mother was always angry and critical. Abuse from teachers continued, and a minister in whom she confided also began abusing her. Yet in spite of her negative experiences with the minister, she became a devout Christian in her college years, and felt the healing power and care of G-d. (based on Rollins, 2005)

This account draws attention to the main questions to be considered in this section. First, accepting the findings (e.g. Silberg, 1998;

Miller & Lisak, 1999) that dissociative personality disorder may be a response to severe stress/trauma, often in childhood, to what extent is such trauma likely to be associated with religion? Second, what roles are played by religion in maintaining or alleviating this condition?

Turning to our first question: given that trauma can be a causal factor in MPD/DID, to what extent is trauma associated with religion? In Rollins's account, given above, just one of several sources of abuse was identified as religious, and the dissociative disorder had appeared prior to abuse by the treacherous priest. Turning to other suggestions about religion and trauma, a widespread and dramatic allegation has been that satanic cults may perpetrate traumatic abuse on children. According to Mulhern (1994), 25–50% of people in treatment for MPD have reported memories of 'ritual torture, incestuous rape, sexual debauchery, sacrifical murder, infanticide and cannibalism' by members of clandestine satanic cults.

Are these allegations true? There have been vigorous attempts to refute them, on the grounds that claims cannot be verified, that therapists have been overeager to suggest false memories, and that those remembering are unduly suggestible.

At one extreme, Mulhern alleges that hundreds of police investigations have failed to corroborate these allegations, leaving a conspiracy theory as an alternative explanation for these presumably false recovered memories. Kenny (2000) regards the anti-cult movement as a witch-hunting venture and, like Mulhern, attaches no credence to the allegations that dissociation has occurred in survivors of child abuse by cult members: 'Poorly digested information concerning trauma and dissociation worked its way down to front-line social workers and helped steer their thinking toward the possibility of ritual abuse.'

A survey of material relating to the idea that the cult abuse-dissociative disorder hypothesis is a conspiracy theory developed by the anti-cult lobby might include the following studies:

- Young, Sachs, Braun & Watkins (1991) described 37 adult dissociative disorder patients who had reported ritual abuse in childhood. They present a clinical syndrome involving dissociative states 'with satanic overtones', severe post-traumatic stress disorder, survivor guilt, bizarre self-abuse and other features. Young

et al. do, however, raise and address issues of reliability, credibility and verifiability.

- Ofshe (1992) offered a detailed study of one case involving the (pseudo-)memories of an adult man of raping his daughters and participating in a baby-murdering satanic cult. Two psychologists said to be predisposed to find satanic cult activity diagnosed the subject as suffering from dissociative disorder. The man was convinced of his guilt for six months, but investigation showed that no evidence supported the man's guilt, and no evidence was found of the alleged crimes. The man was found to be extremely suggestible, and the conclusion was reached that the cult did not exist, and the confessions were coerced.
- Bottoms, Shaver & Goodman (1996) took a stratified random sample of members of the American Psychological Association working in clinical practice. Only a small proportion had encountered allegations of religion-related and ritualistic child abuse. Clients reporting this abuse tended to be diagnosed as suffering from multiple personality disorder, or post-traumatic stress disorder. Abuse was reported either directly by children or retrospectively by adults. The majority of therapists and clinical psychologists hearing these reports believed their clients' claims. However, Bottoms et al. assert that evidence for the allegations, especially those made by adults, is questionable.

It is important to remember that this rather furious debate about allegations of abuse in 'cults' took place in the context of the awakening of public consciousness to the prevalence of child sexual (and other) abuse in general. Early in the development of psychoanalysis, Freud recanted on his view that neurosis originated in childhood trauma, and suggested that his patients' allegations were phantasies (Masson, 1984). Scientific consensus seems to have reinstated Freud's original view, that his patients' accounts of being sexually interfered with when they were children are probably based on truth. This change in consensus emerged at a time when allegations of child abuse were generally being taken more seriously (than previously) by social and health care workers. A prominent reaction to this was the allegation that both adults and children may 'recover' false memories of child abuse, encouraged by eager professionals, and that parents and others were being witch-hunted by overeager professionals wanting to

root out child abuse. It was suggested that some or all memories of child sexual abuse were false. Careful work on recovered memories of trauma, and on the false memory syndrome (Andrews, Brewin, Ochera et al., 2000; Gleaves, Smith, Butler & Spiegel, 2004) has shown that:

- False memories may indeed be encouraged, developed or implanted.
- However, recovered memories are common, and these may sometimes be verifiable. For example, Andrews et al. reported that among therapists' accounts of 236 clients recovering memories during therapy, the majority (65%) of memories were of child sexual abuse, and 'very few' appeared improbable; 41% were corroborated. Techniques to aid recall were used in 42% of cases, but only 22% were used before memory recovery started.
- Genuine recovered memories may differ from false memories in particular ways. For example, in experimental studies, false memories were more likely to contain plausible (but inaccurate) suggested 'filler' items than were genuine memories which had been repressed by a deliberate procedure (memory blocks induced by a retrieval-induced forgetting procedure) (Gleaves et al., 2004).

In the light of these suggestions about recovered memories and false memories, which are based on careful investigation and experiment and systematic review, it does not seem reasonable to dismiss the possibility that perhaps some allegations of child abuse in 'cults'/new religious movements are indeed based on events. The move to dismiss *all* such allegations may be unduly extreme, and itself based on questionable assumptions, for example that the trait of 'suggestibility' is indeed associated with susceptibility to implanted or suggested false memories.

At the moment, then, the suggestion that in some cases multiple personality disorder may result from early traumatic experiences in (some) new religious movements (particularly perhaps satanic and witch-related ones) cannot be ruled out altogether, but the evidence remains very controversial and difficult to substantiate, and the claims of such abuse may be altogether unfounded – the result of witch-hunting.

Are there substantiated claims of early abuse and trauma in 'mainstream', more traditional religious contexts? Readers will have probably come across highly publicised scandals about clergy abuse of children. These and other pieces of evidence indicate that religions do not offer guaranteed protection against child abuse. But the risks of child abuse may not be greater in religious environments compared with other environments, either. The evidence is patchy and rather inconclusive. And possible links with dissociative states and dissociative disorders have not been widely suggested or explored.

Larson, Larson & Koenig (2004), in reviewing research findings on the potential harmful effects of religious commitment on mental health, specifically mention only one study involving multiple personality disorder: Bowman (1989) described 'rigid' religious families, in which parenting practices were very harsh, possibly abusive. Children from such families were said to have negative images of G-d, in addition to any dissociative personality disorder. However, Ganzevoort's (2001, 2002) careful qualitative analyses of religious themes in the stories of male survivors of child sexual abuse do not involve the suggestion that religious factors are markedly implicated in causing or exacerbating child sexual abuse. In his 2002 analysis of common themes in male victims' stories of religion and sexual abuse, Ganzevoort points out that – unlike with female victims – there is a lack of canonical stories, so that narrative patterns are highly individual. Religion and sexual abuse do not usually appear in the same cluster, and religion and sexual abuse are usually spoken of in *contrasting* terms. Ganzevoort writes, for instance, that one victim speaks of his childhood religion in terms of distance and proximity, and describes his experience of sexual abuse in terms of power and powerlessness. Another participant uses religious themes for finding identity, whereas problems in his social life, seen as the results of sexual abuse, involve distance and proximity.

The following description indicates the changing place and functions of religion in the life of one man:

> Frits was born in a large city in the Netherlands, in the late 1940s, the middle of three children. His parents were Roman Catholic, but not very religiously active. There was a tense relationship between his parents. When Frits was six years old, his father began to abuse him sexually. However, when he was taken for a visit to the doctor, the doctor diagnosed venereal disease, and arranged for all the children to be taken into care and placed in a children's home.

Then began a tussle between the mother and the authorities, in which the children were taken home by their mother, then returned into care by the police. This went on for several years and Frits remembered the period as a very unhappy one, in which he consoled himself by religiously inspired images of himself as bearing suffering for the sake of others. During this period he planned to become a priest. A highly intelligent boy, Frits entered university and became inspired by liberation theology. He eventually became a social worker.

Frits had both same-sex and opposite-sex relationships, and remained uncertain about his sexual orientation throughout adulthood. He married, and had two children, but divorced after ten years of marriage. At the time of interview, Frits was living alone but had a female partner. He had taken up painting and writing, but had left the Church. He had been in therapy for some years. (based on Ganzevoort, 2001)

Religion here can be seen as playing varying roles – irrelevant, consoling, liberating and eventually abandoned. In Rollins's account of Annie earlier in this chapter, contrasting roles were played by religious individuals and religious factors – the helpful pastor who took treacherous advantage of the trust of a vulnerable adolescent; then, notwithstanding this betrayal, religion was later found to be an important source of comfort and support.

We cannot see any religious factor as playing a clear single role in fostering abuse. It has sometimes been alleged that religious authority may be used to shield and disguise the perpetrators of physical, sexual and emotional abuse. Readers are probably familiar with the media coverage of priests (and, indeed, doctors, dentists, teachers, police and others in positions of authority and trust) who have betrayed the trust placed in them and abused those over whom they have power. There is no systematic evidence on whether, for instance, those with religious authority are more likely to abuse than those with other kinds of authority, for example, medical, educational, judicial and parental.

A commonly held hypothesis about religion and child abuse was discussed by Capps (1994) in an article entitled 'Religion and child abuse: Perfect together'. Capps quotes a number of (Christian) sources advocating the use of corporal punishment 'for the good of the child'. For example, Fugate (1980) in *What the Bible Says About . . . Child Training* advises: 'Chastisement . . . should never be administered by an angry or emotional parent. If a parent cannot control himself, he should send the child to his room to wait for his

whipping. This action provides the parent with time to "cool down" and it allows the child time to ponder the coming consequences of his actions.' Capps suggested that religious sources might be encouraging the use of physical punishment of children, and that the use of physical punishment might be more likely in more religious homes – leading to potentially physically abusive situations.

This may not be the case. Steley (1996) interviewed a sample of 120 British adults and asked for their recall of the use of physical punishment by their parents, and their parent's religious activity. Steley's main conclusions were that there was *no* relationship between recalled parental religiosity and the use of physical punishment with children under 13; that the more religious parents were *less* likely to use physical punishment on adolescents (over 13); and when parents did use physical punishment, the more religious were less likely to use negative communication (shouting, saying damaging things), and more likely to be recalled as having a child-oriented motive. The more religiously active parents were recalled as having a more positive relationship with their children.

Brody, Stoneman & Flor (1996) also reported that family relations in religious homes are reported more positively than are family relations in homes with low or zero religious activity. Their study was of 90 African-American families in the rural South of the USA.

However, physical punishment has been and still is used in the name of religion. Biale (1983) developed the thesis that physical punishment might have the effect of alienating youth from religion. Adorno, Frenkel-Brunswik, Levinson & Sanford (1950), on the basis of their systematic study of the *Authoritarian Personality*, thought that coercive methods of child discipline were more likely to be associated with authoritarianism, and with a 'neutralised' style of religiosity.

In summary, these observations suggest that in contemporary Western society, and perhaps elsewhere, religious activity may be associated with better family relationships and lower use of physical punishment and (potential) physical abuse. There is less evidence about religion in relation to sexual and emotional abuse. It is perhaps very telling that Weaver, Flannelly, Garbarino et al.'s (2003) systematic review of religion in relation to trauma does not mention any findings of an association between religion and trauma, and does not mention dissociation at all. Essentially, there is no noteworthy evidence to support the hypothesis that aspects of religion

are in themselves causal factors in any form of child abuse, and thus indirectly causal in the development of dissociative disorder.

Some of the material reviewed above has suggested that some features of religion may play a consoling or cheering role for victims of trauma, and that processes involved in dealing with trauma may be seen as spiritual or religious. Benign dissociative processes may be deliberately involved in religious coping, as we have seen, and so may a number of coping beliefs and practices. For instance, Shaw, Joseph & Linley (2005) in a systematic review of evidence on the role of religion and spirituality in post-traumatic growth, conclude that traumatic experiences can lead to a deepening of religion or spirituality, and that religion and spirituality usually – though not always – have a beneficial effect for people dealing with trauma. The most beneficial aspects of religion appear to be religious participation, religious openness and readiness to face existential questions, intrinsic religiosity, and positive religious coping – for example, forgiveness, and possibly the ability to reconstruct one's life story positively. There is a large literature showing generally – though not always – beneficial effects of religion for people dealing with stress, and the crucial aspects of religion are those identified by Shaw et al. as beneficial in dealing with trauma (Loewenthal, 1995a; Pargament, 1997; Koenig, McCullough & Larson, 2001). Another systematic review of religion in relation to trauma (Weaver, Flannelly & Garbarino's review of studies in the *Journal of Traumatic Stress* over the ten-year period 1990–1999) again indicates generally beneficial effects of religion for those coping with trauma, for example higher levels of hopefulness, and spiritual growth. Neither of the systematic reviews (Shaw et al., Weaver et al.) mentions dissociative disorders as negative outcomes of trauma associated with religion. PTSD is mentioned in the religion and trauma literature, but only in the context of the main substance of these reviews, which is to focus on the possible beneficial effects of religious coping resources in dealing with trauma, and spiritual/personal growth as an outcome of dealing with trauma.

Kennedy & Drebing (2002) describe another related area of enquiry. Religiously committed evangelical Christian adults who reported higher frequencies of physical or sexual abuse were more likely to report transliminal/dissociative religious experiences: visions, glossolalia (speaking in tongues) or healing. This again

suggests that forms of benign religious dissociation may result from and/or be used in coping with trauma.

To conclude this section: we have seen that there have been widespread and highly publicised suggestions that dissociative disorders have resulted from trauma occurring in religious contexts, particularly 'cults'. Systematic examinations of the literature have not offered compelling support for this. Although there is some support for the view that dissociative disorders result from trauma, there is no clear evidence that religious circumstances place children, or indeed adults, at greater risk of trauma than other circumstances. The only fairly consistent associations between religion, trauma and dissociation suggested from reviews of the literature are:

- Benign, controlled dissociation may be used as a defence against adverse or traumatic circumstances, and this may be seen as a spiritual process.
- Post-traumatic growth is also often seen as a process of spiritual or religious strengthening.
- Benign forms of dissociative religious activity may be more likely among those with a history of trauma: these may be an effect of trauma, a way of coping, or both.

Religious possession and trance states: are they dissociative?

Can spirit possession and trance states be best understood as dissociative states, or as culturally or religiously specific states or disorders whose understanding is not helped by labelling them as dissociative? In this context, it is worth mentioning a point raised by Varma, Bouri & Wig (1981). In some religious contexts, dissociative states involve an experience of possession by another entity – a spiritual being, sometimes more than one. In other religious contexts, religious dissociative states involve alterations of consciousness – trances, sometimes called hysterical possession – in which the sense of assuming another identity is less definite. Varma et al. suggest that both involve a disturbance of personal identity, but the former, involving multiple personality states, is more likely in cultures in which there is social approval for deliberate role-playing, particularly 'Western' cultures. The latter kind of state, involving alterations of consciousness and

feelings of spirit possession, may be more likely in cultures which support beliefs in reincarnation and spirits. Thus there are strong cultural influences in the forms assumed by dissociation and possession states and disorders.

Here is an example of spirit possession. Is it best understood solely in the religious interpretive terms of those directly involved, or is it helpful to consider it as a form of dissociative (identity) disorder?

A Jewish woman living in eighteenth-century Poland was possessed by a 'Baal Dovor' (demon) which spoke from her throat in Polish. It caused her great physical pain. It would not tolerate her praying, studying (sacred texts) or otherwise using holy words (i.e. liturgical Hebrew), would not let her go to the synagogue, and created a shameful ruckus on one occasion (the Day of Atonement) when she did try to be in the synagogue. Three exorcisms by eminent rabbis were carried out. One gave her a 'kamea' (amulet) to wear. The first two exorcisms were only partially successful, and the spirit returned. The final episode was not a typical exorcism. The victim signalled for the lamps to be lit, complaining that she must be a great sinner to have such suffering. A third voice (not that of the victim or of the spirit) was heard, which sounded disembodied. Witnesses recognised the voice as that of R. Elimelech of Lizensk (a distinguished Hasidic rabbi), who had died some years previously. The voice said that the woman was a 'tzedekes' (righteous or saintly individual), that she would get better, and that she would bear a son. All these predictions were borne out. (based on descriptions in Winkler, 1981)

One view is that the understanding and treating of cases of this kind might not be progressed by regarding them as dissociative states. Here are some criteria for demon (Dybbuk) possession put together from Jewish sources:

- A dybbuk is the soul of a deceased person which has cleaved to (entered) another person (**before** heavenly judgement of the soul). (Possession by a soul **after** its judgement is said to be a *gilgul* and involves a complete 'takeover'.)
- Both the dybbuk and the victim remain conscious and coexist in the same body.
- The victim is typically distressed.
- The victim is more likely to be female than male.
- Special means are necessary to expel the dybbuk (Scholem, 1972; Trachtenberg, 1974; Winkler, 1981).

Table 7.1 *Similarities and differences between demon (dybbuk) possession and dissociative personality disorders (from Loewenthal, 1995b)*

Possession	MPD/DID
A dybbuk is the soul of a deceased person which has entered another person	Two or more distinct identities or personality states (the average number is 15 for females and 8 for males) that recurrently take control of the individual's behaviour
Both the dybbuk and the victim remain conscious and coexist in the same body	An inability to recall important personal information
The victim is typically distressed	
The victim is more likely to be female than male	More likely to be female than male
The quality of the victim's voice is changed ('strange, high-pitched tone')	
Speech may not be accompanied by movements of lips or tongue	
Knowledge of events very unlikely to be accessible to the victim	

Features which may be present (and not typical of possession) are chiefly:

- The quality of the victim's voice is changed ('strange, high-pitched tone').
- Speech may not be accompanied by movements of lips or tongue.
- Knowledge of events is very unlikely to be accessible to the victim.
- A mobile bulge, anywhere in the victim's body.

Table 7.1 summarises some similarities and differences between demon (dybbuk) possession and MPD/DID.

This keeps alive the question whether it is helpful to try to compress all possession and trance states into the category of dissociative disorders. The above example indicates (culture-)specific features which are not considered an intrinsic part of dissociative disorder. The examples that follow are cases of possession and trance states that may be better thought of as culturally religiously specific syndromes, rather than as purely dissociative disorders.

Witztum, Grisaru & Budowski (1996) and Grisaru, Budowski & Witztum (1997) describe states of *Zar* (spirit possession) among Ethiopian immigrants to Israel. *Zar* is not popularly regarded by Ethiopians as matter for as much psychiatric concern as depression. However, in Western eyes the state is often seen as representing psychiatric or neurological disorder. This form of possession is common in parts of Africa, Asia and the Middle East. There may be apathy, convulsive movements, mutism and obscene or unintelligible language. The authors of these two papers regard *Zar* as a culture-bound possession syndrome. Al-Adawi, Martin, Al-Salmi & Ghassani (2001) sugggest that three functions are fulfilled by *Zar* and its exorcism ceremonies: cosmology is reinforced, oppressed individuals – particularly women – may be psychologically manipulated, and exorcism may be a form of culturally defined group therapy. Exorcism involves a shaman, drum beating to appropriate rhythms, dance, adjuring the spirit and, if necessary, whipping it.

Similar to the *Zar* exorcism process is the *Stambali*, 'a ritual trance-dance musical ceremony performed by Tunisian immigrants to Israel'. It is performed only by and for women, and participants are encouraged to dance to exhaustion. Traditionally, the purpose is the exorcism of *jnun* (demons) causing mental or physical illness. However, those interviewed by Somer & Saadon (2000) indicated that women would join a *Stambali* for the promotion of well-being:

> 'When people hear that a *Stambali* is being organised, they come for the release, each with her own issues. Nobody talks about what bothers her, each one is with herself, they don't talk with each other . . . every participant knows what it is she wants to be released from.' (quoted by Somer & Saadon, 2000, p. 585)

Hollan (2000) describes the *Ma'maro* ritual in Tana Toraja, Indonesia. As with *Stambali*, the purpose is to further prosperity and to avoid misfortune, in this case by encouraging *deata* (spirits) to enter the village via the participants. The ceremony involves drum-beating, chanting and dancing:

> 'Our bodies start going like this [jumping and twitching of their own accord]. When we are in front of all the people acting out the *deata*'s wishes, we aren't ashamed, because we have been seized by the *deata*. But after we have recovered for a while, we feel ashamed a little bit . . . because we begin to remember 'Oh, this is what the *deata* had me do.' But most people aren't seized. That's

why we feel a bit shamed, because everyone has been watching us . . . But what can we do? It is not we who are in control. It is the *deata* who are in control.' (quoted by Hollan, 2000, p. 549)

Hollan believes that *Ma'maro* involves dissociation but does not indicate pathology or maladaptation. Similarly, participation in *Stambali* among Tunisian expatriate women, and in *Zar*-related ceremonies in Africa, Asia and the Middle East, seems to have a potentially benign and adaptive function, and the decision to participate appears to be conscious and controlled.

It could be important to distinguish between adaptive dissociative states which are deliberately fostered, sometimes to relieve participants of bad spirits, and sometimes simply to promote well-being, and dissociative states which are experienced as the result of unchosen spirit possession. Both have been viewed as women's normative way of resisting domination in situations of relative powerlessness.

Examples of stress-related trance *disorder* – unchosen, uncontrolled, usually experienced as malign and preceded by episodes or periods of stress include:

- Bartholomew & Sirois (2000) offer descriptions of different forms of occupational mass psychogenic illness (a conversion disorder with dissociative features). One form, mass motor hysteria, involves dissociation, including trance and/or spirit possession, histrionics and psychomotor agitation, which are preceded by tension in the work situation, notably employee dissatisfaction with restrictive management practices, and inhibited negotiation channels – for example, the psychosocial stress placed on women in eighteenth-century England by the introduction of the power loom, resulting in employer preferences for women employees in the cotton industry and disruption of the traditional family structure. Most published reports of this form of 'motor hysteria' come from Malaysia and Singapore, with some outbreaks reported from Europe. Those affected were mainly women.
- Pineros, Rosselli & Calderon (1998) identified a collective episode of psychogenic illness among a group of indigenous people in Colombia. Those affected were mainly women, and the outbreak was precipitated by stress (cultural change). Sufferers saw the condition as being caused by an evil spell (*maleficio)*. The condition was not helped by orthodox psychiatry or even

traditional herbal rememdies. However, shamanistic intervention was helpful.

- Ng (2000) and Ng, Yap, Su et al. (2002) describe dissociative trance disorder in Singapore. DSM-IV criteria were used to identify patients: an altered state of consciousness, partial or total amnesia after the episode, and adoption of at least one alternate identity during the trance state. Most patients felt that they had been possessed by spirits. Patients with trance disorder tended to be less extraverted, and had higher psychoticism, neuroticism and lie scores on the Eysenck Personality Questionnaire. The findings suggested that trances can be seen as stress-induced coping responses, giving a temporary escape from unpleasant reality, and offering some feeling of mastery over intractable difficulties.
- Talla, a 14-year-old Serrer student in Senegal, evinced the signs of a person possessed by ancestral spirits after a troubled childhood in which his father abandoned the family, and a period of major anxiety at school. He was hospitalised with bouts of loss of consciousness, strange visions, cloudy thinking and falls. In hospital a French psychologist treated him by asking for descriptions of his visions and dreams and explanations of his drawing of the spirits that visited him. Eventually, he admitted that one of the spirits was a *rab*, an ancestral spirit, who would not speak to him while he was in the presence of white people. In treatment the psychologist melded modern psychotherapy with beliefs about possession and ancestor spirits, and Talla was able to name the spirits that were tormenting him. His symptoms abated and he was able to return to his studies (Bullard, 2005; Ortigues & Ortigues, 1984).

This material suggests that trance and possession states do have many dissociative features. However, there may be culturally and religiously specific features. Many trance and possession states can be seen as idioms of distress, or as responses to or means of coping with distress, with strong religious and spiritual motifs. Treatment of disturbed people suffering from unwanted possession states by orthodox Western psychiatry is often not helpful. Thus in pragmatic terms, the dissociative psychopathology metaphor may not always be as helpful as the religious-spiritual metaphor, and the indigenous treatment methods based on this conceptual framework.

We began this chapter with the suggestion that dissociative states are ways of responding to and coping with pain, particularly pain arising from trauma. Although religious circumstances can be implicated in causing the kind of pain that can result in dissociation, there is no support for the conclusion that religion is a risk factor for such trauma. However, there are religiously and spiritually inspired ways of coping with trauma which involve benign dissociative techniques.

Trance and spirit possession states can be understood in terms of dissociation, though there may be culture-specific features which may make these states better categorised as culture-specific. Trance and spirit possession may be unwanted, uncontrolled and malign, or be culturally and religiously channelled responses to stress with some beneficial side-effects, or be deliberately fostered as therapeutic. It has been noted that unwanted trance and spirit possession states may not respond well to Western psychiatric treatment, but there are reports of response to indigenous treatments.

8 Positive states

Religion and positive mood: definitions and associations

Finally, we turn to the so far neglected issue of happiness and other positive states of well-being. How do these relate to religion and culture? Do these positive states have any impact on psychopathology?

To begin with, in an attempt to keep the terminology issue as simple as possible, I focused first on finding definitions of the term happiness. Definitions were not offered in any of the handbooks of psychiatry and clinical psychology that I consulted; in fact, it was not even indexed in most. Both our well-worn family *Shorter Oxford English Dictionary* (Little, Fowler & Coulson, 1950) and an up-to-date online dictionary (Longman, accessed 2005) seemed – at first glance – embarrassingly tautological. The Oxford dictionary said that happiness was 'the quality or condition of being happy', while the Longman dictionary, more than fifty years later, had advanced to saying that happiness was 'the state of being happy'. Probing further, however, I found that the Oxford dictionary did offer a fine range of definitions for 'happy', of which the most satisfactory general one was 'having the feeling arising from satisfaction with one's circumstances or condition; also glad, pleased'. The Longman dictionary, very similarly, offered 'having feelings of pleasure, for example because something good has happened to you or you are very satisfied with your life'.

What are the causes of happiness? The Oxford and Longman dictionaries converge in their view of happiness as caused by satisfaction with one's life situation. Barker (1992) offers a fascinating discussion of some literary and philosophical views of happiness, with particular

emphasis on the ability to enjoy sensory experience. Barker quotes Lin Yutang's ability to enjoy the sound of a beautiful clear spring of water, and his view of the world as a 'feast of life spread out for us to enjoy' (Yutang, 1938). Barker suggests that the poet Walt Whitman's spirituality derived similarly from his sensory/sensuous experience: 'a scent to everything, even the snow'. Barker's discussion of happiness suggests that loss of the ability to enjoy sensuous experience may relate to the severely depressed person's loss of awareness of all that he or she has done in life. Diener, Myers and their colleagues report that most people (in the USA, about 90%) report being generally happy, and this is not closely tied to gender, economic status or even health. After disruptive life events, people seem to return to their basic happiness set-point, which is generally consistent from decade to decade, and generally positive for most people. Happy people are generally optimistic and extraverted, have several close friends and high self-esteem, and believe that they have control over their lives (Diener, Sandvik, Pavot & Fujita, 1992; Myers & Diener, 1995; Diener & Diener, 1996; Comer, 1999).

Seligman (2002) suggests that happiness can result from physical pleasure and sensory delights, but suggests that more authentic happiness is the result of more than hedonism, and indeed also more than working for and achieving longed-for goals. Those who have exercised virtue – for example, by helping others – report more lasting positive states than those who have had 'fun' or a good time. In particular, Seligman argues that authentic happiness is related to the exercise of the individual's 'signature strengths' – their preferred virtues. We will return to Seligman's ideas about the causes of happiness later.

How does happiness relate to religion? Religion is associated with raised positive mood. Loewenthal, MacLeod, Goldblatt et al.'s (2000) and Roelofsma's (2003) studies, which indicated this, were described in chapter 4. The Oxford Happiness Inventory (Hills & Argyle, 1998) and other measures of happiness have been used in psychometric studies examining the associations between measures of happiness and of religiosity. Francis, Robbins & White (2003) and Soydemir, Bastida & Gonzalez (2004) reported overall positive relationships between happiness and religiosity, though other work has suggested mixed and weaker relationships (e.g. Hills & Argyle, 1998).

The overall associations with religion are generally with raised positive mood (see chapters 4 and 5) and with lowered negative moods and psychopathology. Might one effect be that religiously inspired positive mood impacts on psychopathology, perhaps by improving poor mood?

There are mixed findings on whether positive mood has a direct effect on depression, with some evidence to support a negative association between positive mood and negative mood, including depression. Of course this does not necessarily mean that cheerfulness reduces depression, but is consistent with this possibility. It has however also been suggested that positive and negative mood states are independently driven (by good and bad circumstances) (Watson, Clark & Tellegen, 1988).

In considering the effects of different moods on each other, it is likely that cognitions play an important role, and the potential for studying the role of religious beliefs in affecting moods is considerable. Some of the relevant work was described in chapter 4 in the section on coping. Some other examples will be offered later in this chapter. Pargament's analyses of coping (1997, 2002) indicates that religion is not a panacea for producing good mood, and causality needs more investigation. The available work does suggest that there may be links between some religious beliefs, positive mood and lower depression. We need to know more about the links between happiness and depression. Although Watson, Clark & Tellegen (1988) have suggested that they are independently driven, there is work suggesting that each may impact on the other.

At the moment, the dominant effect is that religion can have a cheering effect, but work on positive mood and religion has almost entirely been done in Christian cultures. However, all the main religious traditions advocate similar strengths and virtues, and relate these to positive emotional well-being (e.g. Pan, 2003; Watts, Dutton & Gulliford, 2006; Dierendonck & Mohan, 2006).

Some religiously advocated specific strengths and virtues will be examined in this chapter.

Purpose in life, and hope

Viktor Frankl (e.g. 1986) developed his ideas on psychotherapy when, following a Freudian training in Vienna, he was imprisoned

in a concentration camp. As is known, these camps were places of unthinkable horror. Yet Frankl describes how even there, there were people who were still free – free to choose to do a kindness to another, to give away a crust of bread, to bear themselves with dignity. Even in these appalling circumstances, there were people who felt a sense of purpose and meaning. Frankl survived and afterwards developed a system called 'logotherapy', popular in the USA, though little used in Europe, which embodies a number of innovative therapeutic techniques. Frankl became known as the 'father of existential therapy'.

Frankl saw the process of psychotherapy as involving a search – a search for meaning and a discovery of inner strength. He claimed that the majority of clients were suffering from a neurosis so common that it had become normative in civilised twentieth-century America. This he called noogenic neurosis, and its symptom was simply a lack of meaning and purpose in life. Most clients were – and are – suffering from a feeling that they do not know why they are alive, that they have no worthwhile purpose in life, and are not even aware that they would feel better about themselves and others if they were to try to discover a worthy purpose. Frankl saw the therapist's task as facilitating this search. Guttman (2002) and Fabry (2005) offer recent discussions.

Based on Frankl's work, Crumbaugh & Maholick (1969) developed a Purpose in Life test, which has been used to look at the impact of changes in religious belief. Examples of the kinds of feelings characteristic of purpose in life are:

- Usually enthusiastic
- Sees life as exciting
- Enjoys facing daily tasks
- Feels prepared for and unafraid of death
- Sees life as worth while
- Sees a reason for existence.

Frankl's ideas on purpose in life have been applied in the understanding of religious change and its effects on mental health. Paloutzian (1981) looked at students from Christian backgrounds and found that scores on a measure of Purpose in Life were higher among converts than non-converts. His data suggest that purpose in life may

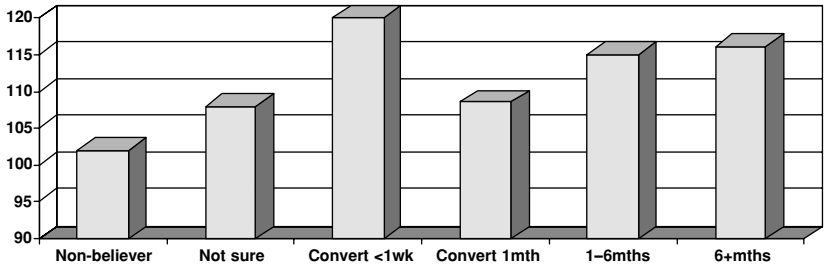

Figure 8.1. Purpose in life in relation to religious belief and time since conversion (based on Paloutzian, 1981, 1996).

rise in an initial period of post-conversion enthusiasm, waver and then stabilise (see Figure 8.1).

The finding that religious conversion and religious activity are associated with raised purpose in life has been confirmed in a number of studies since Paloutzian's 1981 work (e.g. Paloutzian, Richardson & Rambo, 1999; Koenig, 2001; Ng & Shek, 2001).

In general, religious ideas and beliefs derived from religious study are likely to contribute to the repertoire of beliefs and cognitions that contribute to purpose in life and other positive emotional states.

For example, Francis (2000) concluded that Bible reading was one religious activity which made a small but statistically detectable, and unique, contribution to purpose in life.

Another religiously endorsed value is hope, and this is usually considered part of the package of ideas associated with purpose in life. For example, Seligman (2002), discussing the raised levels of physical and mental health and of happiness found among religious people, suggests that, apart from lifestyle factors and social support, religions 'instil hope for the future and create meaning in life' (Seligman, 2002, p. 60).

What do religious people hope for? Seligman quotes Julian of Norwich: 'All shall be well . . . He said not "Thou shalt not be travailed, thou shalt not be diseased", but he said "Thou shalt not be overcome"' (quoted by Seligman, p. 60).

Benzein, Saveman & Norburg (2000) in a study of narratives, asked a group of 15 healthy Pentecostalists in Sweden to describe the meaning of hope. The main features of ultimate hope were life after death, and the future imagined reality as promised by G-d.

Confirming the finding of Francis mentioned above, hope was said to be strengthened by Bible reading, and also by praying, sharing values and experiencing G-d.

Some religious groups – the more strongly committed – are generally more hopeful and optimistic than others; for example, orthodox Jews, fundamentalist Christians and Muslims are more optimistic than reform Jews and Unitarians. The latter, more 'liberal', groups also tend to be more depressive. Raised levels of optimism are associated with the amounts of hope found in sermons, in the liturgy and in stories (Iyengar, described in Seligman, 2002, p. 60).

Hopelessness is often considered a key feature of depression (Beck, Steer, Beck & Newman, 1993; Strohsal, Chiles & Linehan, 1992), and thus religious study and other practices fostering hope may play a double role in reducing depression and raising positive mood.

This optimism may be the result of soul-searching and grappling with existential questions, sometimes as a result of direct experience of severe life events, and sometimes the result of vicarious experience. As Allport (1950) suggested, there may be a bland, mindless complacency, or a more deep-rooted humanitarianism. Hopeful ideas must be set in the context of ultimate human concerns – the inevitability of death and the meaning and purpose of life. Religions play an important role in raising these fundamental existential questions about death and the purpose of life. Alma & Zock (2001) carried out an innovative study in the Amsterdam Opera House in 2002, interviewing members of the audience and performers of Poulenc's opera *Dialogues des Carmelites*. The opera is based on a historical episode: the execution of 16 Carmelite nuns on the scaffold, in Paris in July 1794, and the story deals with the conflicts experienced by a young novice who leaves the order to escape harassment by the revolutionary regime, but then rejoins them as they suffer martyrdom. The producer used no scenery props, and full use is made of traditional prayer and liturgy. The performers

> correctly estimated that the audience was strongly moved by the opera. They concluded this from, among other things, the delay before the audience started applauding at the end of the opera. After the awesome scene in which the guillotine falls for each of the nuns, and finally for Constance and Blanche (the novice and her co-novice), the audience had difficulty breaking the silence. (Alma & Zock, 2001, p. 136)

One performer said:

> 'Never before have I see an impact like the one this opera had . . . it incites people to think about death, their own death, the death of their fellows, the death of people close to them that they have witnessed. I have heard that people need about ten minutes before they can go on again, because it is a very impressive story . . . people get so much out of it, more than just a distraction or a nice evening.' (quoted by Alma & Zock, 2001, p. 136)

One member of the audience said, on the question of what appealed most: 'The human process: how to live (and to die) with fear of death/life' (p. 136).

The majority of the audience were secular: 62% said that they did not feel religiously involved, and 67% said that they were not members of a religious community. Nevertheless, on a four-point Likert-type scale members of the audience thought that several aspects of spiritual and emotional impact warranted an average rating of three or higher, including moving, meaningful, religiously meaningful and spiritually meaningful. Alma & Zock suggest that this religious opera successfully raised universal, existential questions, without trying to offer unequivocal answers.

Existential questions are raised by significant life events – loss, death of close others, illness, trauma of all kinds. There can be profound soul-searching and reevaluation of individual spirituality (Allport, 1950). Psychiatric illness can precipitate such soul-searching. Liebrich (2002) writes:

> Every time I have had an episode of illness in my life, I have been on some kind of spiritual journey by the time it is over . . . I see myself becoming more and more whole . . . Depression is a potential killer . . . although I need to accept the illness, I also need hope. Sometimes I have a kind of miraculous experience, a kind of turning point that involves spiritual insight. I know, deep within, that at these times, I am healing. There are many ways . . . through reflecting with gratitude on the things I have, through focusing on the smallest point of here and now, through letting go of all the things I am trying to control. (Liebrich, 2002, pp. 148–9)

Liebrich goes on to describe how, among other things, she was deeply impressed by the work of Baruk (1998, 1999a, 1999b, 2000) and his belief that psychiatry is a moral discipline, deeply related to spirituality. He considered it a great error that psychiatry had neglected moral and spiritual issues and focused on technical solutions. Crabtree (2005) described patients in a Malaysian psychiatric hospital

engaged in an endeavour to seek spiritual unity, in the effort to regain equilibrium, to repair the fractured sense of self which is often part of the experience of psychiatric illness.

> Foo, a devout Buddhist, spent much time reading as well as practising meditation; energy devoted to spiritual development was seen as essential in the progress to recovery. Edward, a fervent Christian, saw his compulsory admission as a personal test of worth, as well as a time in retreat, much as a monk might see a time of solitude and testing as sacred: 'After being here I feel the Holy Spirit is trying to find out whether I am fit for the task. Now I feel I have received the message . . . my thinking is strong. [Although] G-d has not shown me the way to start my work, he has . . . asked me to wait for the time to arrive. I have the feeling of both fear and happiness, but most of all immense joy.' (Crabtree, 2005, p. 21)

Comparable spiritual journeys have been described by other psychiatric patients (e.g. MacMin & Foskett, 2004), as well as by others, such as Blakeney, Blakeney & Reich's (2005) description of spirituality in the recovery of integrity among Jewish alcoholics and drug addicts, which they epitomize in their title 'Leaps of faith':

> 'When I got pulled over by the cops, I had this total calm, sitting on the curb, when I should have been freaked out . . . right then, it was a spiritual experience . . . It was either stop what I was doing or die. And it was like G-d slapped me in the head and said: "Time to wake up". After that I had a different understanding of how I had to push myself.' (quoted by Blakeney, Blakeney & Reich, 2005, p. 72)

Recurrent themes emerging from these stories include the importance of recognising spirituality and spiritual growth, healing splits and becoming whole, hope, gratitude and forgiveness – themes which also appear recurrently in the positive psychology literature (Seligman, 2002; Watts et al., 2006).

This varied range of evidence says something about the ways in which religions may raise existential questions and offer some solutions, particularly in the form of suggestions about the purpose of life, and reasons for hope.

Forgiveness

To move away from the package involving purpose in life and hope to a quite different religiously endorsed virtue: forgiveness.

Forgiveness, say McCullough & Worthington (1999), rests on three crucial features:

- First, the perception that the actions of another were noxious, harmful, immoral or unjust.
- Second, these perceptions elicit emotional responses such as anger; motivational responses, such as the wish to harm the transgressor; and cognitive or behavioural responses, such as aggression and loss of respect.
- Third, by forgiving, these negative emotional, motivational, cognitive or behavioural responses are modulated, so that more prosocial and harmonious interpersonal relations may be resumed.

Forgiveness has been suggested to involve several stages. Therapeutic interventions involve focusing on negative emotions, particularly anger, and developing ways of coping with these feelings, then making a commitment to forgive, including developing empathy with the to-be-forgiven individual, and finally moving closer towards forgiveness (Worthington, 1998; Enright & Fitzgibbons, 2000; Rye, 2005).

Watts et al. (2006) have pointed out that the understanding of forgiveness might also be seen from the perspective of attribution theory. Here, empathy follows from a shifting of attributions. The damaged person is more likely to see the behaviour of the person who has harmed them as stemming from internal factors, for example malevolence, a wish to harm, or an evil nature. If there is an attributional shift, so that the harmful behaviour is seen as stemming from external factors, such as pain or stress, then empathy may follow without too much further effort. This approach places the emphasis on cognitive factors, so that forgiveness follows from reinterpretation of the situation, leading to empathy, rather than the effort after empathy as such.

One of the most memorable stories I ever read was in a children's book devoted to the theme of judging others favourably. I found the story inspiring because it stimulated me to ingenious efforts at reinterpretation when experiencing unpleasant behaviour. As I remember it, the story went as follows:

Sarah woke up early on her birthday, very excited. There, by her bed, was a small parcel, prettily wrapped. Sarah knew what was in it, because she had chosen it herself, a few days ago, after weeks of begging her parents for her own watch. She opened the package and put the watch on her wrist, impatient to show it to her beloved teacher. Then she ran downstairs to thank her parents for the treasured gift.

Leah woke up early as the alarm rang at 5.30 am. She still had marking to finish and lessons to prepare before her children woke up, and she hurried to prepare her school work, tired because she had been woken up in the night by a noisy thunderstorm and torrential rain. There were strange noises coming from the basement. She opened the basement door and discovered that the basement was flooded; the basket of clean clothes waiting to be taken upstairs for the children to wear that day had been somehow knocked into the floodwater. Aghast, she sloshed through the floodwater and tried frantically to deal with rinsing and drying the clothes in time for the children, and mopping up some of the flood. As she finally rushed into school, exhausted and five minutes late, with the marking still unfinished, she was confronted by a child thrusting a watch under her nose, tapping the watch face.

At the time, the harassed teacher was unlikely, indeed unable, to interpret the excited child's apparent impatience as anything other than impertinence. However, the story does stimulate the reader to make creative attempts to interpret unintelligible (and even, in other cases, seemingly unforgivable) behaviour.

McCullough & Worthington consider the religious roots of forgiveness – which is endorsed in the major religious traditions – and consider whether religion and interpersonal forgiveness are indeed found to be related, empirically. They also consider possible impacts on mental health.

The relationship between religious involvement and forgiveness is strong, when forgiveness is assessed as a *general* trait. The relationship is weaker, though still reported in some studies, when examining forgiveness in *specific* situations – for example, when individuals are asked to think of someone who has harmed them in the past, and to assess their current feelings towards that person. McCullough & Worthington have some interesting suggestions about reasons for the discrepancy between findings on forgiveness as a general trait, which relates strongly to religious involvement, and findings on forgiveness in specific situations, which relates weakly to religious involvement. For example, they suggest that the influence of religion on transgression-specific forgiveness might be quite distal in the causal chain. While religiously involved individuals may feel more strongly than others that they ought to forgive, many other factors, such as whether the transgressor apologised, or whether the effects of the transgression were persistent, affect the likelihood of forgiving (Girard & Mullet, 1997).

Watts et al. also point out that the process of forgiveness is complicated by the very serious moral and psychological dilemmas posed by situations such as child abuse, torture and murder, and events such as those reported in the Holocaust. One Holocaust survivor recalled being asked whether she could forgive those who had killed her family, and she replied that she felt that she had no moral right to exercise forgiveness for what had been done to others. Although Derrida (2001) has argued that forgiveness 'only comes into its own when something unforgivable has happened', survivors of serious and persistent child abuse, and those working with them, can find the possibility of empathy and forgiveness bizarre, far-fetched and unhelpful, particularly since the kinds of reinterpretation that can facilitate forgiveness are difficult or impossible for some kinds of actions. The sufferer quoted by MacMin & Foskett (2004) is using a probably significant choice of words. The sufferer talks of '*trying* [my italics] to forgive', then of *forgetting*, and then of *moving on*. The full quotation is:

> 'G-d has become my everything. I know that without my faith I would not have survived the child sexual abuse, the abusive relationships I went on to develop, the suicide attempts made by my son, the loneliness, and abandonment of my partners, and the church; the poverty, the depression, the bereavements, the stigma of being a lone parent at a time when it was still quite rare, the homelessness . . . I could go on and on . . . however, I do thank "G-d" for my faith. It allows me to try and forgive, forget and move on. The pain is always there, and the healing will take forever, and I do have the hope of my faith and that is all that matters now.' (Mental Health Foundation, 2002; MacMin & Foskett, 2004, quoted on p. 33)

Nevertheless, forgiveness can be facilitated, or simply 'found', and rightly so, in many cases, even if there are some times when it is not always possible or appropriate. Rye (2005), Sells & Hargrave (1998) and Enright (e.g. Enright, Gassin & Wu, 1992) are among other authors who have drawn attention to possible associations between religious involvement and forgiveness, to the possible importance of forgiveness in interpersonal relationships and personal well-being, and to the possibility of facilitating forgiveness. Rye reports that participants in forgiveness groups – single college students wronged in a romantic relationship, or divorcees – scored higher after participation on measures of forgiveness and of existential well-being, compared with no-intervention controls. Rye says that although a

religious forgiveness intervention produced similar results to a secular intervention, this may have been because the participants in the secular intervention groups were spontaneously using religious and spiritual strategies.

Watts et al. have pointed out that while there has been some advance in the study and understanding of forgiveness from the perspective of the person who has been wronged or damaged, there has been negligible study of the processes and effects of *being forgiven*. They suggest that this is something strongly endorsed in religious traditions – that the wrongdoer recognises that harm has been done, acknowledges this, and makes efforts to rectify things and seek forgiveness. This aspect of forgiveness deserves attention.

Does forgiveness relate to well-being? It has been reported to be associated with increased hope, higher life satisfaction, lower depression and anxiety, and higher self-esteem and relationship adjustment (McCullough & Worthington, 1999; Rye, 2005).

Forgiveness is one example of a positive state or process which is religiously endorsed and encouraged, and although the relations between religion and forgiveness are not yet clear and need further study, there is some evidence that religion may foster forgiveness, and that forgiveness can enhance well-being.

Authentic happiness

There is growing emphasis on the importance of focusing on positive psychology (notably by Seligman, e.g. 2002). The positive psychology view is that psychology focuses too much on negative states and pathology. Seligman strongly suggests that more time – personally and professionally – should be spent focusing on positive states and virtues. This has given rise to a new source of interest in religion and spirituality as an aspect of human experience. Religious and spiritual values are seen as important human strengths and sources of well-being.

Seligman has argued, and offered empirical support, for the idea that authentic happiness is not closely tied to material well-being, whereas exercising virtues and 'signature strengths' is. One of Seligman's important concepts is the idea of 'signature strengths': these are strengths of character that a person is aware of, and enjoys using on a daily basis. Seligman suggests that developing these can improve

happiness and well-being, as well as lowering negative moods including depression – and there is empirical support for this.

It is noteworthy that spirituality/religiosity is now seen, for almost the first time in psychology, as an important strength and an important aspect of human character. Most of the other strengths are qualities which are encouraged and valued in religious traditions, such as forgiveness, honesty, love, gratitude, justice and kindness.

There are a total of 24 possible 'signature strengths', and in Seligman's (2002) presentation these are grouped into five clusters. Here are the five clusters, and examples of strengths within each cluster, and of questions used to asses them (those interested in carrying out a full self-assessment may do so, free of charge, by visiting the website www.authentichappiness.org and taking the strengths survey):

Cluster 1: Wisdom and knowledge: routes to displaying wisdom, and its necessary antecedent, knowledge, can be arranged in a developmental progression, from curiosity, love of learning, critical thinking, ingenuity, social intelligence and perspective.

In the following examples of strengths, each statement is rated as one of the following:

- Very much like me
- Like me
- Neutral
- Unlike me
- Very much unlike me

- Curiosity/interest in the world: 'The statement "I am always curious about the world" is . . .'
- Perspective: 'The statement "I am always able to look at things and see the big picture" is . . .'

Cluster 2: Courage: the conscious exercise of will towards worthy ends that are not certain of attainment.

- Valour and bravery: 'The statement "I have taken frequent stands in the face of strong opposition" is . . .'
- Integrity/honesty: 'The statement "I always keep my promises" is . . .'

Cluster 3: Humanity and love: strengths displayed in positive social interaction with other people.

- Kindness and generosity: 'The statement "I have voluntarily helped a neighbour in the last month" fis . . .'
- Leadership: 'The statement "I can always get people to do things without nagging them" is . . .'

Cluster 4: Temperance: appropriate and moderate expression of appetites and wants.

- Self-control: 'The statement "I control my emotions" is . . .'
- Humility and modesty: 'The statement "I change the subject when people pay me compliments" is . . .'

Cluster 5: Transcendance: emotional strengths that reach outside and beyond to connect you to something larger and more permanent. This cluster includes spirituality, gratitude, hope and forgiveness, as well as appreciation of beauty, humour and zest.

- Spirituality/sense of purpose/religiousness. 'The statement "My life has a strong purpose" is . . .'
- Zest/enthusiasm: 'The statement "I throw myself into everything I do" is . . .'

Although some of these questions might invite 'faking-good', socially desirable responses, these and other measures on the authentic happiness website are reported to have good psychometric properties.

Seligman believes that each person possesses several signature strengths, strengths of character that a person self-consciously owns as being 'the real me'. Seligman's formula for the good life is: 'Use your signature strengths every day in the main realms of your life to bring abundant gratification and authentic happiness' (Seligman, 2002, p. 249).

Seligman and his colleagues are producing a rich genre of work on positive psychology, offering empirical support that mental disorders may be reduced by focusing on the development of authentic happiness, and of signature strengths. There is growing interest in the interface between developments in positive psychology in religion (Joseph, 2006).

Much of this thinking is encapsulated in a moving narrative related in an interview I carried out with a Holocaust survivor (Mrs X) in the 1980s (Loewenthal, 1988). The survivor described how she survived, but that all her family were lost, and as she grew into

adulthood she abandoned the religious practices from her happy childhood home and became very angry with G-d for what had happened. Then her husband became involved with a group of religiously active Jews – Lubavitch Chasidim – and he was invited to meet their leader, the Rebbe. Mrs X was asked if she wanted to go. At first she said 'No', then she became more belligerent, and decided that she would go. 'I was going to shock this rabbi. I was going to tell him what happened to my family, I was going to tell him what I thought of his G-d.' So she went to the USA. The Rebbe was himself a survivor and had escaped there in the 1940s, and he listened to her angry tirade.

'The Rebbe said, "I am very happy to hear you are so angry with G-d." I was shocked. What could he mean? He said: "If you are angry, that is already a very strong connection." Then he said: 'I know you like to give, so ensure that you give something to charity each day, and also try to say "Thank G-d" whenever you can.' I said afterwards to my husband, how will giving money to charity and saying "Thank G-d" help? How can that help anything? How can it help what happened? But you know, it did help . . .'. (from an interview conducted by the author)

We can conclude that there is a broad overall association between religion and raised levels of happiness. This chapter explored some of the possible pathways. In particular, religious study may promote the development of purpose in life and of hope, which in turn promote greater well-being and lower depression. Forgiveness is another religiously encouraged virtue. This is an important topic of current research, and possible pathways linking religion, forgiveness and well-being were discussed. Finally, the movement towards positive psychology was briefly described, and its links with religious factors indicated.

9 Conclusion

Can religious factors cause or exacerbate mental disorders? Can they ameliorate them? And how might effects depend on culture?

We can obviously reach the general conclusion that religious factors can affect mental health, sometimes for the good, sometimes not, and some of these effects can vary with cultural context.

A number of common ideas and stereotypes about religion, culture and mental health have been examined. Not all of them seem to stand up in the light of current evidence, patchy and imperfect as this might be.

For instance, there is little evidence that religious factors can play a *causal* role in mental disorder. Some of the suggestions which have been made on this topic include:

- Religion makes people feel guilty, provoking anxiety disorders – including and perhaps especially obsessive compulsive disorder.
- Some religions encourage paranormal experiences, the seeing of visions, hearing voices and other experiences which are delusory, and this may cause psychiatric breakdown.
- Religions may legitimate various forms of abuse, for the sake of enforcing religious rules, and this has psychiatric effects – depression, dissociation and post-traumatic stress disorder.

We have seen that there is little or no support for these suggestions: religion may influence the *form* of OCD, but there is no evidence to suggest that its *likelihood* is influenced. Visions and voices may be encouraged in some religious traditions, but they do not in themselves result in psychiatric breakdown – their unpleasantness and lack of controllability seems to be the crucial factor, and this is not related to religious factors. There is, however, some suggestion that

meditation may precipitate manic breakdown in susceptible individuals. Although there are clearly many records of abuse perpetrated in the name of religion, or sometimes cloaked by religion, religions and religious influences are not *more* likely to lead to abuse (in fact may be less likely) than other influences.

Although religious factors may play a very limited role in exacerbating mental disorder, there is much evidence to suggest that the *forms* of mental disorder are influenced by the religious-cultural context. There are many examples of culture-specific disorders, usually with a strong religious flavour. Religious beliefs may help to entrench some symptoms, for example somatic, depressive or other symptoms believed to be caused by demons or evil spells or personal spiritual failings.

These same beliefs may, however, be helpful in relieving some symptoms. For example, it has been reported that sometimes – though not invariably – treatments based on such beliefs may be successful when orthodox medical or psychiatric help is unsuccessful. There are several ways in which religious coping can be helpful in psychiatric disorders – a good, trusting relationship with G-d, for example, is a good prognosticator of improvement in depressive illness, and this effect may be robust across different religious traditions and cultures. Religiously fostered dissociative strategies can be reported as helpful – glossolalia, or forms of guided imagery or meditation and contemplation, for example. Finally, there is a range of virtues and positive psychological states encouraged by religious traditions, such as forgiveness, purpose in life and hope. These may have good effects on mental health.

It has been suggested that the study of positive psychology and its therapeutic effects has been overlooked in the past, and it is certainly the case that much future work in this area could focus on the contributions of different religious-cultural traditions to positive states of mind.

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