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.