Beliefs about the efficacy of religious, medical and psychotherapeutic interventions for depression and schizophrenia among women from different cultural-religious groups in Great Britain.

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Beliefs about the efficacy of religious, medical and psychotherapeutic interventions for depression and schizophrenia among women from different cultural-religious groups in Great Britain.

In a semi-structured interview study we examined the views of 59 adult women from five cultural-religious groups in Britain, on the efficacy of different forms of help for depression and schizophrenia. Groups represented were Black Christian, White Christian, Hindu, Jewish and Muslim. The main foci of interest were to examine which forms of religious help were perceived as most effective, and to compare the perceived effects of religious help with psychopharmacological and psychotherapeutic interventions, Of possible religious interventions, prayer was most often seen as helpful. For depression, prayer was seen as most often helpful of the interventions discussed. Between-group differences are described. Religious factors were clearly seen as important in managing mental illness, and this has implications for help-seeking and adherence.

Background

Lay beliefs about mental illness have been studied in the general British population (Furnham, 1988; Kuyken, Brewin, Power & Furnham, 1992), but little is known about cultural-religious variations in such beliefs. Weiss (1997) has stimulated interest in cultural differences in concepts of mental health and illness using the EMIC (Explanatory Model Interview Catalogue) which yields qualitative and quantitative data enabling the study of belief systems of local communities on topics such as patterns of distress, causes of illness, and help-seeking. Unlike Weiss, in this study we did not look at beliefs about patterns of mental illness. Instead we focused on two standard diagnostic categories, major depression, and schizophrenia, focusing on commonalities and variations between groups in beliefs about forms of help. We reasoned that even though there are cultural-religious differences in the definition and categorisation of illnesses (MacLachlan, 1997; Weiss, 1997) when the health service consumer confronts the health professional in the UK or elsewhere in the western world, transactions are going to involve standard diagnostic categories. We therefore asked how religious-cultural group membership affected beliefs about helpful interventions for depression and schizophrenia. We were particularly interested in how views on the effectiveness of religious help compared with views on the effectiveness of

professional help.

There is growing evidence of a large body of religiously-based beliefs and practices in different groups, which may complement or conflict with those of orthodox medicine and psychiatry (e.g. Bhugra, 1992; El Azayem & Hedayat-Diba, 1994; Loewenthal, 1995; Littlewood & Dein, 1995; Bartholomew & O'Dea, 1998). To quote a few examples:

1) some groups may believe depression to be impossible in the truly religious individual, and so depression will be denied if it occurs;

2) some religious sources or authorities may state that the devout individual should not consult a psychotherapist or similar professional since this may lead the person to irreligious ideas and practices;

3) sufferers may use a range of religiously endorsed coping strategies and beliefs alongside orthodox psychiatric or similar help, without telling professional helpers, for fear of being misunderstood or branded as superstitious. Sufferers may pray, consults with religious healing authorities, fast, and use herbal or remedies (Griffith, 1983; Campion & Bhugra, 1997). Aspects of religion may be associated with remission (Verghese, John Rajkumar et al, 1989), and the hope or perception of remission may delay or prevent help-seeking (Bhugra, Hilwig, Hussein et al, 1996).

Religious beliefs and practices could have marked

impact on help-seeking. We know that these kinds of beliefs and practices may exist, but we know little about their detailed content, or their distribution within and between different cultural-religious groups. Some existing information comes from clinical cases, other information from religious texts, and some from studies of religious healing outside the UK (Sandoval, 1979; Griffith, 1983; Campion & Bhugra, 1997) but there is little from non-clinical samples of lay informants.

In this study we targeted non-clinical samples from several cultural-religious groups in the UK (table 1), and carried out semi-structured open-ended interviews to enable participants to tell us what they believed to be the effectiveness of different forms of help for depression and schizophrenia. Our aims were: to understand in what ways religious help was perceived to be effective (or ineffective) for depression and schizophrenia, among the cultural-religious groups studied; to compare the perceived effectiveness of religious help with other forms of help; and to consider how this information might be important in psychiatric practice.

Method

Participants

59 adult women participated, from five cultural-religious groups in the UK. Women were chosen, first

because in some minority groups, gender matching of interviewer and interviewee is essential and all our minority-group interviewers were women; second because in our research experience, men from some minority groups have not been as interested in mental health topics as women, leading to a high refusal rate. The age range was 18-65, with a mean age of 35 years. 86% were married, and 71% had children, with a mean of 1.9 children. The criteria for inclusion were that each participant should be female and should claim affiliation with the targeted religious group. We did not select participants for level of religious practice, as we lacked resources to develop a measure that would enable comparability between all the groups studied. Matched interviewers from the same ethnic/cultural/religious background carried out the interviews and provided transcripts, translated into English where necessary. Table 1 shows socio-demographic characteristics.

INSERT TABLE 1 ABOUT HERE

Participants psychiatric history was unknown at the time of recruitment, since questions on this were felt to be threatening at this stage. However participants were asked an optional question at the end of the interview,

whether they had anything to do with anyone suffering from depression or schizophrenia. Most participants (68%) reported first-hand experience of depression, either experienced by themselves (35%) and/or among friends and relatives. Fewer (28%) reported first-hand experience of schizophrenia, among friends, relatives and/or acquaintances; no participants reporting having suffered schizophrenia themselves.

The interview

An extended semi-structured interview was used (available on request from the authors). Interviews were conducted in participants' homes, and took approximately two hours. All interviews were tape-recorded, with participants' consent. Participants were first asked what they understood by the terms depression and schizophrenia, and then definitions of major depression and schizophrenia were offered. Views on causes and treatment were sought, covering views on medication, medical and other types of professional help, and religious resources. The interview schedule followed a "funnel" approach, first asking general questions with appropriate probes, allowing participants own ideas to be elaborated. Then more focused questions were asked on specific causes and treatments.

Interviews were transcribed and where necessary translated by the interviewers.

Results

The study was chiefly qualitative. Some quantitative data were obtained, but small numbers permit only descriptive and not inferential statistics.

Definitions and causes of depression and schizophrenia

In the preliminary part of the interview we asked participants to talk about their own understanding of depression and schizophrenia, and how these conditions were caused. Participants had little difficulty in producing lists of depression symptoms resembling the DSM criteria. First-hand experience of schizophrenia was less frequent, compared to depression, and definitions were less confident and less complete. There was no evidence of between-group variation in the definition of either illness. When the DSM-III definitions were offered by the interviewer, there were no signs of confusion or disagreement; the definitions were often met with outright approval: "that's right, I'd forgotten about that symptom".

Among suggested causes for depression and schizophrenia, religious factors were more important for depression than for schizophrenia:

For depression: causes suggested stress (such as loss, illness, family and marital problems, work overload, menopause and post-natal factors) was seen as the principal

cause, while biological factors, lack of religious faith, lack of social support, lack of sleep, and the weather were thought to contribute in some cases. Among religious causes, lack of faith was most widely suggested. Muslims were particularly eloquent on this point:

> "...pray to Allah and leave it to Him. If we accept that whatever happens comes from Allah then all the problems are solved and you accept your fate and do not try to fight it, and you don't feel frustrated and then you don't get depressed".

Schizophrenia: this was thought to come from the blue, biologically caused. Stress, lack of religious faith, lack of social support, lack of sleep and the weather were suggested to play a minor role in some cases.

Forms of help for depression and schizophrenia

Table 2 summarises salient views on the different forms of help discussed, for all the participants regardless of group.

INSERT TABLE 2 ABOUT HERE

We focus on three forms of intervention: medication which was seen as the chief treatment offered both by general practitioners and psychiatrists; psychotherapy, the

"talking cure", and prayer which was the most salient of the religious interventions discussed by the participants.

For depression, the prevalent view of medication was that it was a superficial form of help only:

"*People take (anti-depressants) just to try and raise their spirits, but they just give an artificial high, by numbing the emotion*" (Black Christian);

"*I think it's a cover-up, I don't think it's a cure*" (Jew).

Psychotherapy was seen more positively. It

"*gives (the person) more attention, would be more help*" (White Christian), and

"*makes you aware of why things are happening to you, it makes a world of difference*" (Jew).

Prayer was seen most often as helpful, particularly for the religious believer. It

"*can help in depression, but it doesn't work unless you believe that it's helpful*" (White Christian),

"*it can provide a sense of hope*" (Black Christian),

"*it helps because you have faith in something*" (Hindu),

"*you can find a tremendous strength in it*" (Jew),

"*it saves from going into a deep depression*" (Muslim).

For schizophrenia, medication was generally seen as essential;

"*to control it*" (Hindu);

"*not to be ill with schizophrenia you have to have long-term medication*" (White Christian);

"*they should be on medicines*" (Muslim).

Psychotherapy was seldom described as helpful for schizophrenia, but prayer was often seen as offering a modest but definite form of help: prayer

"*may help to comfort them, but not to overcome it*" (Hindu);

"*if you pray you will suffer less*" (Muslim).

Figure 1 summarises how often medication, psychotherapy and prayer were seen as helpful for depression and schizophrenia, across all participants.

INSERT FIGURE 1 ABOUT HERE

The most notable feature is the striking extent to which prayer was seen as effective. For depression, prayer was more often seen as helpful, compared to medication and psychotherapy. Even though schizophrenia was usually seen as a biologically-based condition for which drugs were a "necessity", prayer was widely-regarded as helpful.

Inter-group differences

How did the different cultural-religious groups differ in their views? Tables 3 and 4 show inter-group variations.

INSERT TABLE 3 ABOUT HERE

INSERT TABLE 4 ABOUT HERE

The figures in tables 3 and 4 suggest that Christians and Muslims were the most often convinced about the value of prayer. A possibly-relevant qualitative observation was that Muslims, Black Christians and some Jews described a form of prayer in which a personal, emotionally expressive confiding was made towards God who was seen as powerful, caring and trustworthy.

> "*Well I think if you know there's a God that's there listening to your prayers, OK you won't get a response, but just by talking to him I think it helps, yeah...He's always going to be there for you and He's not going to tell nobody your business...I know when I feel a bit down I pray and I feel better by just praying*" (Black Christian).
>
> "*It does not matter how depressed you are, if one can divert your attention towards prayer (your low feelings) can disappear...giving all problems to Allah and having faith in Him is very therapeutic*" (Muslim).
>
> "*When I'm depressed, I can say, all right G-d, if this is your idea of a joke that's fine, I can go along with it*" (Jewish).

Another noteworthy group characteristic was expressed by White Christians, who reported a widespread practice of praying for others who were known to be in distress. The feelings of community and belongingness, as well as the possibility that God might be more likely to respond to a multiplicity of pleas:

> "*You feel better just knowing that other people are praying for you*" (White Christian).

Other forms of religious help: religious leaders and holy persons.

As well as prayer, some participants thought that religious leaders and holy persons might sometimes be helpful. Two forms of help were mentioned: first, the religious leader as a source of advice and counsel, and second (less commonly advocated) the holy person as a channel of healing or blessing.

Seeking advice and counsel from a priest, rabbi or other religious leader was sometimes thought to be helpful, particularly for depression, but participants were conscious of the differing sensitivities and skills of the clergy compared to mental health professionals:

> "*Personally I would first consult a (professional) person who is non-religious. If I felt they didn't understand the religious context I might switch if I thought it was a problem*" (Jewish).

Muslims were particularly likely to express the view that religious help should come from a direct personal approach to God:

> "*In our religion we don't need a person to take our religious responsibilities, nothing like the Pope, or Archbishop, or Brahmin, or Rabbi. Every one of us is responsible to learn what we can by ourselves. In our religion we can talk to God directly, we don't need help from anyone*" (Muslim).

The holy person who acts as a possible channel for healing was sometimes advocated, more commonly for schizophrenia than for depression, but most participants said that they personally would not resort to this:

> "*...(if their family) back home is like that, and they believe in holy men and things like that...but educated people will avoid this*" (Muslim);
>
> "*Probably in the older generation if you've got a mental illness, they think you've got a bad spirit in you, and that's why you hear all these voices and that's why this person is telling you to do things...they'll just think: oh, go to holy person and they will cure you. If you talk to my generation they will probably know that it is something different*" (Hindu).

Discussion

The participants in this study were clear that

religious forms of help - and particularly prayer - could be as helpful or more helpful than medication or psychotherapy. Prayer was seen as important and helpful for depression, but we were surprised at how often prayer was seen as helpful for schizophrenia. Prayer was seen as particularly helpful for those with religious faith. Other forms of religious help were more controversial, but often approved. In their views on the helpfulness of religion and particularly prayer, the similarities between the different groups outweighed the differences. The five groups' views on prayer converged in seeing prayer as offering comfort and support, and it was widely thought that prayer was more helpful for those with faith. Nobody suggested explicitly that prayer helped as a result of divine intervention.

Some noteworthy group differences in beliefs about prayer included the (white) Christian view of the helpfulness of knowing that others were praying for one, compared with the Muslim and Black Christian emphasis on privacy. Muslims were negative about seeking outside religious counsel and healing, Black Christians were negative about professional help. We can only offer piecemeal observations by way of understanding these different profiles of views about prayer. Relevant factors might include the fact that there may be higher proportions of whites, Jews and Hindus in the mental health professions, which may lead people from these groups to

have better expectations of feeling understood and of not meeting racism - compared with black and Muslim people. Another important factor in the perceived importance of prayer might be general importance of religion for identity (Royle & Barrett, in press), social support and self-esteem (Griffiths, 1983; Shams & Jackson, 1993, Loewenthal, 1995) - and the importance of religion in these respects may have varied among the groups studied, perhaps being higher among the blank Christians and Muslims.

When we consider the implications for help-seeking and adherence, at first sight we might suppose that the use of prayer and other religious resources might co-exist in peaceful parallel with other forms of help-seeking.

However we suggest that help-seeking for both depression and schizophrenia might be significantly delayed or completely avoided, partly because of hope that prayer or other religious help may be effective (Griffith, 1983; Loewenthal, 1995; Campion & Bhugra, 1997), and partly because of fear that religious beliefs and behaviour may be misunderstood (Loewenthal, in press; Bartholomew & O'Dea, 1998). Prayer and other forms of religious help may be resorted to prior to seeking professional attention, and their palliative effects can be perceived as quite high. If and when professional help is sought, mention of any religious means that have been tried will be avoided.

There were methodological problems in designing a study of this kind which may limit its applicability.

Measurement of levels of religiosity among the different groups was a technical problem beyond the scope of this study, since indices of religiosity are quite different in each of the groups studied, and so it would have been difficult to achieve comparability between groups.

Questions were raised which can only be resolved by future research in which the problems of sampling and measurement of religiosity have been resolved more certainly. For example, are religious factors more important for minority ethnic groups than for the majority? And for how many people are religious factors important in mental illness, and under what circumstances?

In spite of these difficulties, the study has implications for psychiatric practice and attitude:

1) Religious practices and beliefs are important to a number of people, who may avoid or delay seeking professional help for mental health problems, partly in the hope that religious resources will be helpful, for example by offering a sense of comfort and purpose, and partly for fear that their religious beliefs and behaviour may be misunderstood. These fears are not groundless: misdiagnosis on the basis of non-pathological religious behaviours and beliefs are not only possible (Barker, 1996; Bartholomew & O'Shea, 1998) but well-documented (Loewenthal, 1995, and in press). Thus professionals could improve trust, and avoid misdiagnosis, by trying not to misjudge religious beliefs

and behaviour.

2) Some of the communities offer religiously-appropriate support for people under stress. There are several centres for Asians, Muslims, Black and white Christians, and Jews in London and elsewhere. Such centres in small, close communities may be avoided because attendance could become public knowledge and hence stigmatization. Prayer, and the private seeking of religious support and counsel, may be preferred. These are likely to be tried before seeking professional help.

3) Discussion of religious beliefs and practices are likely to be avoided in encounters with professionals, leading to areas of opacity and poorer understanding of the total context of patient's lives.

4) We found little direct evidence that professionals were feared because they might advocate beliefs and practices that might be antithetical to patients' religious beliefs and practices. However religious factors might lead to reserve and caution when consulting professional mental health workers.

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Table 1: Numbers, mean ages, marital status and mean number of children of participants in each cultural-religious group.

	Hindu	Black Christian	White Christian	Jewish	Muslim	ALL
	India	British Caribbean	British	Mixed European	Pakistan	
Number	9	7	17	13	13	59
Age	37.6	35.7	36.5	40.4	35.0	
Married						
Number of children						

Note: brief descriptions of the different groups are given in appendix 1.

Table 2: summary of salient beliefs, across all participants, about different forms of help for depression and schizophrenia.

Type of help	Depression	Schizophrenia
Medication	*Mixed support, most negative *May help but superficial *Doesn't tackle root causes *Unpleasant side-effects *Can create dependency	*Seen as the only option *May help but does not cure *No other palliative *Unpleasant side-effects but usually less horrible than Sz
Doctor (General Practitioner)	*Too busy to give time *May not believe in depression *Can be supportive *Drugs only	*Medical help definitely need for Sz *Route to psychiatrist
Psychiatrist	*Hybrid doctor/psychotherapist	*The real expert for Sz, which is seen as a biological/medical problem
Social worker	*Can tackle social causes *May be too directive	*Unlikely to be helpful
Psychotherapist Counsellor Psychologist	*Helps to understand roots of problem *May help to reach solution or learning to live with it.	*Unlikely to be helpful
Religion: prayer	*Certainly helpful, especially for believers *Comforts, improves mood.	*Might help a little, in bearing the problem. *No harm in praying for a cure
Religion: beliefs	*Probably helpful	*Unlikely to be helpful *Might be harmful: "Why me?"
Religion: leaders	*Mixed views. May be helpful	*Might help a little *A few people might hope to experience

a "miracle cure"

Table 3: Percentages agreeing that medication, psychotherapy and prayer are helpful for depression.

Form of help	Black Christian	White Christian	Hindu	Jewish	Muslim	ALL
Medication	29	71	56	54	69	53
Psycho-therapy	29	88	89	62	62	69
Prayer	86	94	67	62	92	81

Table 4: Percentages agreeing that medication, psychotherapy and prayer are helpful for schizophrenia.

Form of help	Black Christian	White Christian	Hindu	Jewish	Muslim	ALL
Medication	43	94	56	54	85	71
Psycho-therapy	14	76	78	23	92	61
Prayer	71	82	44	31	69	61

Figure 1: Percentages agreeing that medication, psychotherapy and prayer are helpful for depression and schizophrenia.