Spirituality and Cultural Psychiatry

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*Belo had been sent away from his Indonesian village for aggressive and threatening behaviour. Doctors could not help. He saw himself as on a mission to seek the purpose of life from a guru in a different area. When he returned, he said 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 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, also that he could see through objects and into the future, and that he was a prophet. He threatened and beat up "bad" children, destroyed banana plants, and the villagers were worried about future disasters. Among the villagers, there was much debate about what to do about Belo – should he be expelled again, or sent to hospital – but this could be 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. In spite of this difference of opinion, Belo agreed to the hen sacrifice. Belo was also given herbal treatment. Over the years, Belo suffered intermittent attacks of craziness, and was sometimes locked up. 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 (*Broch, 2001*).*

Jonah has become a much more religiously observant Jew over the years. As in other orthodox Jewish homes, his family kitchen has different utensils for cooking and serving milk and meat foods. However, 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, he alleges, so 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 feel they are being driven crazy, but Jonah insisted that his actions and beliefs are religiously appropriate and he does not need help. Finally he was persuaded to seek professional advice. (Greenberg. 1987; Greenberg & Witztum, 2001).

*Ellen, a Pentecostalist Christian, was born in the West Indies and lives in London, working as a psychiatric nursing auxiliary. She is a religious enthusiast: patients and colleagues tolerate her attempts to convert them, and to persuade them that Jesus will help them more than the doctors can. One day, she starts rolling on the floor, babbling incoherently. The psychiatrist who witnessed this wondered if she was practicing glossolalia – speaking in tongues - encouraged in Pentecostalism. He invited an opinion from her fellow church-members. They said that this was not genuine speaking in tongues: she was ill and needed medication. (*Littlewood & Lipsedge, 1997).

These examples throw up several important themes in considering spirituality in the context of cultural psychiatry:

- Spirituality is an essential premise, and a core aspect of self-concept and of coping.
- Spiritual and religious forces are seen to play a key role in shaping beliefs and behaviours – including unacceptable ones.
- Spiritual and religious beliefs are an intrinsic feature of the cultural group, therefore difficult to distinguish from cultural factors.
- However the sufferer and his or her social circle may have different views on precisely which spiritual and religious factors are important, for example whether

Belo's actions were being controlled by a Jin, Tuhan (Allah), or Om, or whether Jonah had gone too far with his religious scruples.

- Spiritual and religious beliefs influence the kinds of help believed to be effective and acceptable.

These lead to questions, and this chapter will discuss some of these.

Aims

In this chapter we will first consider several aspects of the relations between cultural psychiatry, and spiritual and religious issues. In particular, we ask:

- Do spirituality and religiosity need to be distinguished?
- What role does spirituality play in cultural psychiatry?
- Can we distinguish spiritual from cultural factors?
- Can we generalise from Western, Christian studies on spirituality in relation to mental health?

Then we examine, in the context of cultural psychiatry how spiritual and religious factors affect:

- the prevalence of psychiatric illnesses,
- help-seeking and compliance,
- diagnosis, and decisions about clinical management and therapy.

Psychiatry and spirituality, some issues.

Psychiatry and the related mental health professions have had a long and sometimes difficult relationship with spiritual and religious issues, and cultural factors are often deeply embedded in these difficulties.

Here are four particular issues:

1. *Do spirituality & religiosity need to be distinguished*?

Religiosity is in itself difficult to define, given the many social, cognitive, experiential and other factors involved. Am I religious because I identify myself as an orthodox Jew? Because I believe in G-d? Because I am aware of G-d's presence? G-d's unity? G-d's support? Most authors would accept that religion involves affiliation and identification with a religious group, cognitive factors – beliefs, and emotional and experiential factors (Brown, 1987; Paloutzian, 1996; Loewenthal, 2000). In the last decade, there has been growing emphasis on spirituality, as something different or separable from religion (Zinnbauer, Pargament, Cole, Rye, Butter, Belavich, Hipp, Scott & Kadar, 1997; Speck, 1998). Wulff (1997) suggested that spirituality is possibly a contemporary alternative to religion in to-day's pluralistic society. King & Dein (1998) argued that using spirituality as a variable in psychiatric research encompasses a broader range of both people and experiences than does the religious variable: spirituality is "a person's experience of, or a belief in, a power apart from their own existence" and that power is revered and sacred. Spirituality might be what all religious-cultural traditions have in common, and, contemporary commentators say, is an aspect of human experience open to those who do not identify with a specific religious tradition.. Helminiak (1996) argued that the study of spirituality can be undertaken scientifically, and is "different from the psychology of religion as generally conceived". Zinnbauer et al found a number of features that distinguished adults who defined themselves as religious, from adults who defined themselves a spiritual but not religious. Those who said they were spiritual but not religious were more likely to engage in New Age religious beliefs and practices, but were less likely to be engaged with the beliefs and practices of traditional religions. However, it is noteworthy that in the Zinnbauer at al study, all those who defined themselves as religious, *also* regarded themselves as spiritual.

This indicates support for the view that spirituality is possible outside the context of organised or traditional religion, but is also a common feature of different religious traditions. When the term "religious" is used in this chapter, this has the implication that

spirituality is an essential feature. There are additionally, practices and beliefs specific to a given cultural-religious group.

2. *What role has spirituality played in psychiatry?*

Spirituality has been problematic for psychiatry for two reasons.

First, the "demon problem".

J has violent abdominal pains and insists that these are caused by bad spirits unleashed by a former friend, whose boyfriend has left her and taken up with J.

The person who believes that s/he is being persecuted by malign spiritual forces presents dilemmas for the clinician. How helpful is it to think of this delusory? Would s/he be better off without a spiritual belief system, or is the belief system simply affecting the shaping of symptoms? Should spiritually-based remedies be deployed? Is the person in fact suffering from psychiatric illness?

Belief in possession by malign spiritual forces has been a long-standing problem in psychiatry. Kroll & Bachrach (1982) and Lipsedge (1996) reviewed medieval documentation to conclude that in the past demons were not invariably regarded as the only possible causes of psychiatric illness: stress, fever and malnutrition were more likely to be seen as causal factors. Nevertheless, belief in malign spiritual forces as possible causes of psychiatric illness is probably culturally and historically universal, even though stress and other factors are also seen as important, by lay people as well by those professions empowered to help the psychologically disturbed (e.g. Pfeifer, 1994; Srinivasan &Thara, 2004; Loewenthal, in press).

There are two factors – the conviction that illness may be caused by malign spiritual forces, and the possibility that the positive symptoms of schizophrenia, delusions and hallucinations, may be common among non-disordered people – that make for difficulties in diagnosis and treatment.

The “demon” problem is only one way in which spiritual issues obtrude in psychiatry.

The second major set of difficulties is the debate over whether religion is consoling or harmful. The consolations of religion have been recognised by the provision of chaplaincies in psychiatric hospitals. Towards the end of theC18th, there were attempts to treat the insane more humanely, and spiritual issues were important. But attitudes were as mixed as they were strong. In the 1790s, Tuke, a Quaker merchant, founded the York retreat, where prayer and religious devotion were seen as central to the healing process. In Britain the Lunacy Act of 1890 ordered a church in every asylum, which the inmates had to attend twice a day. In France, by contrast, Pinel – who abolished chains for the insane in the Bicetre - insisted that the mentally ill should not be exposed to religious practices as it was felt that these might encourage delusions and hallucinations.

These contrasting attitudes and practices appear elsewhere. Thus Freud (1927, 1928, 1930, 1939), spearheaded a movement which viewed religion as possibly crippling for psychological health. A few weeks ago, at a meeting involving users of mental health services, one user complained that although she and her fellow-Christians on their psychiatric ward found prayer and bible study very helpful (and indeed as we shall see there is considerable scientific support for this) – they were not permitted to organise ward prayer meetings or bible study sessions. The Christian patients believed that the ward staff feared that this would “make some patients worse”.

There is some mutual mistrust, with religious authority figures suggesting that the “psych” professions – psychiatrists, psychoanalysts, psychotherapists, clinical psychologists – are not to be trusted. For example: “Psychoanalysis has effected no cures. Freud and his cohorts are charlatans and vampires that prey upon society” (Miller, 1984).

Neeleman & Persaud (1995), treading a cautious path, suggest that religious and spiritual issues are indeed outside the clinician’s area of competence, and could therefore best left alone in negotiating treatments. Recent years have seen less reticence. For example, there

have been strongly-advocated moves for reconciliation between spirituality and psychotherapy, that spirituality should be taken into account in psychiatric and therapeutic practice (e.g. Bhugra, 1996; King-Spooner & Newnes, 2001, Foskett, 2004; Pargament & Tarakeshwar, 2005; Crossley & Salter, 2005).

3. *Can we distinguish spiritual and cultural factors affecting mental illness?*

The question was highlighted for me when a psychiatrist commented that he thought that studying religion and mental health was the same thing as studying culture and mental health. King & Dein suggest that psychiatrists regard spirituality as "cultural noise to be respected but not addressed directly".

Works on cultural psychiatry normally offer much material involving spiritual issues, with spiritual and religious factors subsumed under the heading of culture – Belo's story from the beginning of this chapter is one example.

To the observing ethnographer, or the visiting psychiatrist, religious and spiritual beliefs and practices may be seen as part and parcel of the culture. For the western-trained psychiatrist, religious factors may seem distinct from culture only when they appear in a patient from the same cultural group. But we can see from the examples that began this chapter, that discussions about clinical management among the patient's *own* group often seem to involve strategies that are specifically spiritual and religious. This could be important, particularly because we need to understand the importance for users of the *spiritual* sanctioning and origins of their behaviour – as with Belo and Jonah - and also the importance of the religious endorsement of clinical interventions. For example, Belo, Jonah and Ellen all felt their behaviour was spiritually-inspired. Also it was important for Belo to accept that the hen sacrifice would be spiritually valid, for Jonah to accept that his rabbi approved his psychiatric treatment, and for Ellen to know that her fellow-church-members thought she should have medicine. These behaviours and decisions were

embedded in particular cultural context, but it is the *spiritual* dimensions that have special significance for understanding, and for clinical management.

4. *Can conclusions about spirituality and religion in relation to mental health, based on research in Western Christian groups, be applied to other cultural-religious groups?*

There are two suggestions in particular that need airing.

One is that religion has generally benign effects on health and mental health (e.g. Koenig, McCullough & Larson, 2001). This is a broad conclusion: some effects are null, and some are negative. Some aspects and styles of religion and spirituality may be unhelpful. Outstanding examples have emerged from Pargament and his collaborators (e.g. Pargament, 1997) on styles of religious coping that have positive and negative outcomes on well-being: for example, belief that G-d is supportive is helpful, belief that G-d is angry is reliably associated with poor outcomes. Studies of religion and mental health have problems with research methods. Most studies have involved a cross-sectional design: most researchers have studied the relations between measures of spirituality/religion and health/mental health at one point in time. This makes it difficult to draw conclusions about what is causing what. Prospective studies would enable firmer conclusions, but there are (as yet) few of these. The biggest problem in the context of our present concerns, is the narrow range of religious traditions (mainly Christian) and cultures (North-American and other Western cultures). There have been only a small number of studies of Hindus, Jews, Muslims and other groups.

So the first suggestion that needs examining in the transcultural context is that spirituality may be beneficial for mental health. The rich ethnographic material available suggest that findings from current research cannot always be generalised into other cultural contexts.

The second suggestion is that not only psychiatric but also spiritual support can be offered by a professional with appropriate training. This is an issue in culture-sensitive

service provision that is likely to become a topic for debate in the future. Can, say a Christian minister, with training in and understanding of the beliefs and customs of other faith traditions, provide a form of spiritual support that is acceptable and helpful to members of other religious traditions, for example Muslims, Jews, Hindus, even Christians of other denominational affiliations. This is a contentious issue: members of some religious groups may be happy to receive some *professional* (i.e. psychiatric, clinical-psychological) mental health support from professionals outside their religious group, even though they might have reservations about whether they are being fully understood (e.g. Cinnirella & Loewenthal, 1999). However they might feel that *spiritual* support needs to come from an qualified religious leader in their own tradition. Some chaplains may find that they can offer support to members of other faiths, and this may be gratefully accepted, but this probably does not imply that this service going to serve all needs across the board, obviating the need for religiously-specific support.

Having reviewed these preliminary issues – whether spirituality and religion need to be distinguished, the varied role played in psychiatry by spiritual issues, the difficulty of distinguishing spiritual and cultural factors, and generalisability of research on Western Christians to other groups – we now turn to examine the ways in which spirituality might affect prevalence, help-seeking, compliance, diagnosis and decisions about clinical management.

Prevalence

Cultural and spiritual/religious factors may affect prevalence and referral rates for different conditions.

Depression: Overall, there is a reliable association between higher religiosity and lower levels of depression (e.g. Koenig, 1998; Koenig et al, 2001; Loewenthal, in press). There are some aspects of religiosity that are exceptions to this general tendency, but a

number of features of religion have now been identified that are likely to play a causal role in ameliorating or preventing depression. These include:

- religiously-based coping beliefs (Maton, 1989; Pargament, 1997; Loewenthal, MacLeod, Goldblatt et al, 2000; Koenig et al, 2001) particularly the belief that G-d is benign and supportive
- social support - warm and confiding relationships, esteem, practical help, and companionship are all encouraged among religious groups (Shams & Jackson, 1993; Loewenthal, 2000).
- reduced stress – at least some stressors of the type that could cause depression (e.g. Loewenthal, Goldblatt, Gorton *et al*, 1997a).
- positive mood states, many of which are religiously encouraged, play a role in reducing depressive mood and illness. These include purpose in life, joy, optimism, and forgiveness (Seligman, 2002; Joseph, in press).

The main aspects of religion which may foster depression are first, beliefs that G-d is punishing, vengeful, or simply indifferent (Pargament, 1997), and secondly situations in which religious forces encourage persecution, warfare and other horrific circumstances. However it remains unclear whether these things are more likely to be encouraged in the name of religion, than they are in the name of some non-religious ideology, such as socialist justice, liberty, equality and fraternity, or a Great Leap Forward.

Another factor affecting depression prevalence is a combination of gender and religiously-supported attitudes to alcohol use. Depression is widely concluded to be more prevalent among women than among men (Paykel, 1991; Cochrane, 1993). Referral rates also show a similar pattern. However, there are some groups among which depression may be as prevalent among men as among women: (orthodox) Jews (Levav, Kohn et al, 1993; 1997; Loewenthal, Goldblatt, Gorton et al, 1995) the Amish, diabetics (Bradley, 1999), actively-religious Christians (Kendler, Gardner & Prescott, 1997). What these groups have in common is low or no use of alcohol. The alcohol-depression hypothesis suggests that societies in which men are as likely to be depressed as women

are ones in which (particularly men's) depression is not masked by alcohol use and abuse (Loewenthal, MacLeod et al, 2003a, 2003b).

The overall effect in most studies is a reduced likelihood of depressed mood and illness among the religiously active.

Anxiety: this has been less heavily-investigated in relation to spirituality, than has depression. There seem to be two important and conflicting effects.

First, spirituality and religious commitment are usually associated with feelings of obligation to perform religious duties. Earlier commentators, notably Freud (1907) commented that this relieved guilt, but it has become more apparent that spiritual satisfaction is an important factor. This might involve scrupulosity with regard to diet, religiously-prescribed cleanliness, or caring for others for example. A number of studies have indicated that religiosity is associated with higher levels of sub-clinical anxiety and obsessionality (Lewis, 1998; Loewenthal, Goldblatt, Gorton et al, 1997b). Clinical levels of anxiety and obsessive-compulsive disorder are not more likely among the religiously active, though cultural-religious context can affect the shaping of symptoms (Greenberg & Witztum, 2001).

The second important effect works in the opposite direction. Heightened spirituality, religious faith, awareness that (once one has done what is humanly possible) all is in the hands of heaven – these beliefs and states of awareness are associated with lower anxiety. This effect can be obscured by the tendency for individuals under stress to increase their levels of religious and spiritual activity – notably prayer and meditation. In cross-sectional studies this can give a muddled picture. But with sufficient attention to research design, measurement and interpretation, there is now reasonable confidence that these effects dominate the relations between anxiety and religious/spiritual factors (Koenig et al, 2001).

Psychosis: schizophrenia is sometimes said to be roughly similar in its prevalence across different cultural groups – a lifetime prevalence of approximately one in 200. It is admitted that diagnostic criteria can vary, and there is still vigorous debate about the nature and classification of psychosis (Bentall & Beck, 2004). Variations in prevalence may be a result of variations in the occurrence and classification of culture-specific symptoms and syndromes. An important example is the misdiagnosis of fervent prayer and other religious coping behaviour as psychotic symptomatology. Bipolar (manic-depressive) disorder may be influenced by spiritual factors, notably meditation (Wilson, 1997). Yorston (2001) has suggested that meditation may precipitate manic episodes, possibly the result of neuropsychological factors. It is possible that the affected individuals are predisposed to the disorder (perhaps as a result of genetic factors), and the spiritual practices which are followed by manic episodes may have been attempts to cope with depressive episodes.

One important conclusion is that prevalence estimates may rest on diagnoses based on "symptoms" which are in fact attempts to cope, stimulated by stress, often using spiritual and religious devices which may be quite effective. This can make it difficult to disentangle the conflicting effects of culture, religion and spirituality on prevalence, but the existence of conflicting effects does not imply inconclusiveness. A further noteworthy point is that there are many culture-specific symptoms and syndromes, with religiously-flavoured symptoms: again the causal roles of spiritual and religious factors are complex.

Help-seeking and compliance.

Prevalence is not necessarily reflected in referral rates. Of the many aspects of religion and spirituality that might affect help-seeking and referral, we can identify two broad groups of factors: firstly, religious and spiritual factors affecting views about treatments and ways of coping, and second religious and spiritual factors affecting social-psychological dynamics.

Views about treatments and ways of coping: religious coping, religiously-influenced beliefs about the efficacy and acceptability of different treatments and coping methods.

Particularly in exclusive religious groups, religious and spiritual resources within the group may be seen as offering effective relief from mental health difficulties (Koenig, 1998; Greenberg & Witzrum, 2001; Loewenthal, 2005; Leavey, Loewenthal & King, under review), and the practices and beliefs of mental health professionals are unacceptable religiously, spiritually harmful, and ineffective.

> *"We treat such problems in the community. We give the person with difficulties a boost, talking about belief, and trust in G-d, saying we must not despair…everything is from Heaven"* (orthodox rabbi, quoted in Greenberg & Witztum, 2001).

Some early work suggested that clients were generally more religiously-active than mental health professionals, even though more recent work (e.g. Roskes, Dixon & Lehman, 1998) suggests that this may no longer be the case. The outrageously anti-religious statements of Freud and others may have helped to foster a view that it is spiritually dangerous to seek psychological help. There may be more specific concerns: that psychologists and psychiatrists might encourage or condone sexual or other behaviours that are not religiously-acceptable – homosexuality, for example, or speaking disrespectfully about parents (Loewenthal, 2005). Some professionals may misunderstand or fail to consider their patient's spiritual and religious concerns.

There is of course growing evidence of the effectiveness of much religious coping: prayer, trust, belief in a benevolent, fair G-d, perception of purpose – all these have been empirically shown as effective (e.g. Pargament, 1997; Maltby, Lewis & Day, 1999; Loewenthal, MacLeod, Goldblatt et al, 2000), and they are perceived as effective (Loewenthal, Cinnirella et al, 2001). There is also growing consensus that the majority of users and potential users of mental health services are generally pragmatic in their use of different kinds of help for psychological problems: use is determined by availability and cost-effectiveness, and preferably confidentiality. Clients will shop around until they find something accessible that works. These factors can help to explain the relative

popularity of prayer, religious and spiritual healing (Campion & Bhugra, 1997; Sembhi & Dein, 1998; Loewenthal & Cinnirella, 1999) .

These beliefs – the effectiveness and accessibility of spiritually-based help and coping methods, and religious barriers to seeking professional help, combine to give the result that substantial numbers of patients – up to 70% or more in some studies – will have used one or more spiritually-based treatment before seeking professional help.

It is unknown for what proportion of people who use spiritually-based support or help, that help is sufficiently effective, or there is "spontaneous" remission, so that further help is not sought. Some professionals may be concerned the religious and spiritual barriers to seeking professional help may result in further deterioration. This is an important concern, but there is no substantial evidence in place as yet.

Religious and spiritual factors affecting social-psychological dynamics: trust for clinicians, stigma and the own-group dilemma.

There are social-psychological effects that rest on religious and spiritual factors, and which affect help-seeking and referral. Foremost among these is *stigma* – the fear that one is or will be discredited by significant others. Stigmatisation is likely to be associated with mental illness, and strong in close-knit religious groups (e.g. Muslim, Black Christian, orthodox-Jewish). For example*:*

- *"Our people do not want everyone to know they have a problem".*
- *"I would think that many people would prefer something more confidential than an open meeting".*
- *"What kind of people would use this (service)? Must be people who can't cope".*

While members of many religious groups say that they would feel best understood by a professional who shares their own religious background, they also have fears that this might lead to their condition becoming known:

- *"I would think twice before going to a counsellor from my community. I would not want everyone to know"*.

(Examples from Cinnirella & Loewenthal, 1999; Loewenthal & Brooke-Rogers, 2004).

Stigmatisation almost certainly occurs more strongly in tightly-knit religious groups and collectivist social milieux, than it does complex, urbanized, individualistic societies. So insofar as religious and spiritual factors play a role in the formation and maintenance of close-knit, collectivist groups, stigmatization is a likely by-product. This is hypothetical, and empirical work on this topic is lacking.

Adherence

Adherence may be difficult to assess in psychiatry and psychotherapy, but can reflected in taking prescribed medication, keeping appointments, or developing an acceptable working relationship, and these are all related to trust and confidence in the professional. Trust and confidence are likely to be higher for a professional who is seen to understand and respect clients' explanatory models (Bhui & Bhugra, 2002), including spirituality, and who may be able to address any spiritual concerns (Fabrega, Lopez-Ibor, Wig, Sims et al, 2000; Pargament & Tarakeshwar; 2005).

However some caution is needed. Pargament et al list some of the potential dangers of spiritually-sensitive therapy, for example, overestimating the importance of spirituality.

Individuals may feel that using a professional from their own cultural-religious group will involve a feeling that their spiritual concerns are best understood, but as mentioned, there are raised concerns about stigma and confidentiality involved in consulting an own-group professionals. Even if these are resolved by finding a professional from another geographical area, where there is less likelihood of the consultation becoming known, problems can remain. As Cunin et al (1993) point out, the client may have magical expectations of the therapist, over-idealise them, and expect him or her to give advice which is not appropriate in the therapeutic situation. Dein (2002), Loewenthal & Brooke-

Rogers (2004), Fernando (2005) and others have discussed some of the difficulties in implementing culturally and spiritually-sensitive mental health care. Apart from the financial difficulties experienced by those providing such services, which almost always spring from the voluntary sector, there is almost no research funding and effort invested in discovering whether the extent that cultural-religious matching of providers and clients really:

- results in more effective services,
- results in matching explanatory models (or maps),
- whether the latter is important for adherence, and improved outcomes.

Diagnosis and clinical management.

Diagnostic and treatment decisions can be based on patients' religious behaviours and feelings. There are also at least two diagnostic areas in which there may be biases based on information about religious behaviour and affiliation: psychosis, and obsessive-compulsive disorder.

Many religions endorse and encourage spiritual experiences and behaviours which might be construed as psychotic symptoms: the hearing of voices, visions, and religious practices such as glossolalia, ecstatic states, trances, dancing, and other behaviours involving dissociative phenomena.

There is a growing amount of work to suggest that:

- visions, voices and experiences that may often be interpreted as spiritual are genuine from the experiential and phenomenological perspective;
- among psychotic patients, these experiences are significantly more unpleasant, uncontrollable and persistent than among others (Peters, Day, McKenna & Orbach, 1999; Davies, Griffiths & Vice, 2001)
- a range of visions, voices and other hallucinatory experiences are extremely common among those *not* suffering from psychiatric problems. They are seldom

reported for fear of being taken as signs of madness (e.g. Hinton, Hufford & Kirmayer, 2005).

Nevertheless, these behaviours may be taken as symptoms of psychosis. This may be one cause of the so-called Afro-Caribbean schizophrenia "problem": higher referral and possibly prevalence of schizophrenia among Afro-Caribbeans in western countries. Ineichen (1991), and Thomas, Stone, Osborn & Thomas (1993) and Loewenthal & Cinnirella (2003) reported that schizophrenia is more commonly diagnosed among AfroCaribbeans in the UK, than it is among other ethnic groups, and that this overdiagnosis occurs for Afro-Caribbeans in Europe and the USA, but not in Africa or the Caribbean. Littlewood & Lipsedge (1981a, 1981b) found that a form of Sz with a relatively good prognosis was more common among AfroCaribbeans than among other groups, and this was characterised by "religiously-flavoured symptoms". One explanation, based on Bhugra (2002) is that when individuals (from ethnic-religious minority groups) are under stress, they may adopt religious coping strategies, which decline when – for whatever reason – there is remission. Thus religious behaviours are not so much a symptom of distress but a form of coping. This is speculative, but there is much in the clinical literature to confirm that the past tendency to misdiagnose religious coping behaviour as symptomatic of psychopathology, may still persist (Loewenthal, 1999).

If one knows that a religious tradition requires cleanliness before prayer, or purification from sin for example by confession, it is tempting to conclude that obsessive-compulsive disorder (OCD) may be fostered by these religious demands, by the over-zealous wish for spiritual purity. Nevertheless it has been concluded that – while religiosity may be associated with non-clinical scrupulosity, and can influence *which* obsessional symptoms are developed in OCD, it does not actually cause OCD. But as with psychosis, there may a persistent diagnostic bias. Gartner, Hermatz, Hohman & Larson (1990) Yossifova & Loewenthal (1999), and Lewis (2001) all found that both clinicians, clinical trainees and lay people were more likely to diagnose OCD when a patient was described as religiously-active.

Nevertheless, we cannot conclude that patient religiosity, spirituality and cultural background have a uniformly negative effect on clinical decision-making, although this is a persistent fear among potential patients. There is no striking evidence of diagnostic biases regarding clinical conditions other than schizophrenia and OCD. In one recent study, Janes (2005) found that clinical outcomes were rated (by clinicians) as just as good for psychotic patients with religious symptoms, as for psychotic patients with other symptoms. Many clinicians are aware of the possibilities for the diagnostic biases associated with patients' religious behaviour, and make efforts to overcome these biases (Littlewood & Lipsedge, 1997)

Conclusion

This chapter has looked at cultural-spiritual-religious factors and their impact in cultural psychiatry. In providing services, and in making clinical decisions, it is important to bear in mind that specific spiritual beliefs and practices are not uniform within any culture.

Three kinds of effects of spirituality on mental health seem to be important. First, that while there are some damaging effects of spiritual beliefs and practices, these may be outweighed by the beneficial effects. Work on how and whether these beneficial effects may be harnessed to bring clinical benefits is only in very preliminary stages. Second, there may be unhelpful diagnostic biases and clinical decisions based patients' religiosity and spirituality, particularly perhaps when religious practices are culturally unfamiliar. It needs to be explored whether these exist for disorders other than schizophrenia and OCD, and whether they are pervasive and persistent. Third, religious coping behaviour is felt to be spiritually and psychologically beneficial. However when individuals are under stress there may be an increase in religious coping, and this can lead to an impression that the religious behaviour is a sign of illness. This effect needs to be explored carefully in longitudinal studies, and is a possibility that clinicians need to bear in mind.